



General Assembly

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Amendment

LCO No. 8230

HB0700008230HDO

Offered by:

REP. MERRILL, 54th Dist.

REP. MALONE, 47th Dist.

REP. HAMM, 34th Dist.

SEN. HARP, 10th Dist.

SEN. PRAGUE, 19th Dist.

SEN. MURPHY, 16th Dist.

To: House Bill No. 7000

File No. 701

Cal. No. 491

**"AN ACT CONCERNING THE EXPENDITURES OF THE
DEPARTMENT OF SOCIAL SERVICES."**

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Section 17b-261 of the general statutes, as amended by
4 public acts 05-1 and 05-43, is repealed and the following is substituted
5 in lieu thereof (*Effective July 1, 2005*):

6 (a) Medical assistance shall be provided for any otherwise eligible
7 person whose income, including any available support from legally
8 liable relatives and the income of the person's spouse or dependent
9 child, is not more than one hundred forty-three per cent, pending
10 approval of a federal waiver applied for pursuant to subsection (d) of
11 this section, of the benefit amount paid to a person with no income
12 under the temporary family assistance program in the appropriate
13 region of residence and if such person is an institutionalized

14 individual as defined in Section 1917(c) of the Social Security Act, 42
15 USC 1396p(c), and has not made an assignment or transfer or other
16 disposition of property for less than fair market value for the purpose
17 of establishing eligibility for benefits or assistance under this section.
18 Any such disposition shall be treated in accordance with Section
19 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
20 property made on behalf of an applicant or recipient or the spouse of
21 an applicant or recipient by a guardian, conservator, person
22 authorized to make such disposition pursuant to a power of attorney
23 or other person so authorized by law shall be attributed to such
24 applicant, recipient or spouse. A disposition of property ordered by a
25 court shall be evaluated in accordance with the standards applied to
26 any other such disposition for the purpose of determining eligibility.
27 The commissioner shall establish the standards for eligibility for
28 medical assistance at one hundred forty-three per cent of the benefit
29 amount paid to a family unit of equal size with no income under the
30 temporary family assistance program in the appropriate region of
31 residence, pending federal approval, except that the medical assistance
32 program shall provide coverage to persons under the age of nineteen
33 up to one hundred eighty-five per cent of the federal poverty level
34 without an asset limit. Said medical assistance program shall also
35 provide coverage to persons under the age of nineteen and their
36 parents and needy caretaker relatives who qualify for coverage under
37 Section 1931 of the Social Security Act with family income up to one
38 hundred fifty per cent of the federal poverty level without an asset
39 limit, upon the request of such a person or upon a redetermination of
40 eligibility. Such levels shall be based on the regional differences in
41 such benefit amount, if applicable, unless such levels based on regional
42 differences are not in conformance with federal law. Any income in
43 excess of the applicable amounts shall be applied as may be required
44 by said federal law, and assistance shall be granted for the balance of
45 the cost of authorized medical assistance. All contracts entered into on
46 and after July 1, 1997, pursuant to this section shall include provisions
47 for collaboration of managed care organizations with the Healthy
48 Families Connecticut Program established pursuant to section 17a-56.

49 The Commissioner of Social Services shall provide applicants for
50 assistance under this section, at the time of application, with a written
51 statement advising them of the effect of an assignment or transfer or
52 other disposition of property on eligibility for benefits or assistance.

53 (b) For the purposes of the Medicaid program, the Commissioner of
54 Social Services shall consider parental income and resources as
55 available to a child under eighteen years of age who is living with his
56 or her parents and is blind or disabled for purposes of the Medicaid
57 program, or to any other child under twenty-one years of age who is
58 living with his or her parents.

59 (c) For the purposes of determining eligibility for the Medicaid
60 program, an available asset is one that is actually available to the
61 applicant or one that the applicant has the legal right, authority or
62 power to obtain or to have applied for the applicant's general or
63 medical support. If the terms of a trust provide for the support of an
64 applicant, the refusal of a trustee to make a distribution from the trust
65 does not render the trust an unavailable asset. Notwithstanding the
66 provisions of this subsection, the availability of funds in a trust or
67 similar instrument funded in whole or in part by the applicant or the
68 applicant's spouse shall be determined pursuant to the Omnibus
69 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
70 this subsection shall not apply to special needs trust, as defined in 42
71 USC 1396p(d)(4)(A).

72 (d) The transfer of an asset in exchange for other valuable
73 consideration shall be allowable to the extent the value of the other
74 valuable consideration is equal to or greater than the value of the asset
75 transferred.

76 (e) The Commissioner of Social Services shall seek a waiver from
77 federal law to permit federal financial participation for Medicaid
78 expenditures for families with incomes of one hundred forty-three per
79 cent of the temporary family assistance program payment standard.

80 [(f) Notwithstanding the provisions of subsection (a) of this section,

81 on or after April 1, 2003, all parent and needy caretaker relatives with
82 incomes exceeding one hundred per cent of the federal poverty level,
83 who are receiving medical assistance pursuant to this section, shall be
84 ineligible for such medical assistance. On and after February 28, 2003,
85 the Department of Social Services shall not accept applications for
86 medical assistance program coverage under Section 1931 of the Social
87 Security Act from parent and needy caretaker relatives with incomes
88 exceeding one hundred per cent of the federal poverty level until on or
89 after July 1, 2005.]

90 [(g)] (f) To the extent permitted by federal law, Medicaid eligibility
91 shall be extended for [two years] one year to a family that becomes
92 ineligible for medical assistance under Section 1931 of the Social
93 Security Act [while] due to income from employment by one of its
94 members who is a caretaker relative is employed or due to receipt of
95 child support income. A family receiving extended benefits on the
96 effective date of this section shall receive the balance of such extended
97 benefits, provided no such family shall receive more than twelve
98 additional months of such benefits.

99 [(h)] (g) An institutionalized spouse applying for Medicaid and
100 having a spouse living in the community shall be required, to the
101 maximum extent permitted by law, to divert income to such
102 community spouse in order to raise the community spouse's income to
103 the level of the minimum monthly needs allowance, as described in
104 Section 1924 of the Social Security Act. Such diversion of income shall
105 occur before the community spouse is allowed to retain assets in excess
106 of the community spouse protected amount described in Section 1924
107 of the Social Security Act. The Commissioner of Social Services,
108 pursuant to section 17b-10, may implement the provisions of this
109 subsection while in the process of adopting regulations, provided the
110 commissioner prints notice of intent to adopt the regulations in the
111 Connecticut Law Journal within twenty days of adopting such policy.
112 Such policy shall be valid until the time final regulations are effective.

113 [(i)] Any person receiving medical assistance pursuant to subsection

114 (g) of this section who becomes ineligible for such assistance from
115 March 31, 2005, to May 31, 2005, inclusive, shall continue to be eligible
116 for such medical assistance through June 30, 2005. On and after July 1,
117 2005, such person shall not be eligible for medical assistance provided
118 in accordance with this subsection and the Department of Social
119 Services shall not pay for any such assistance provided to such person
120 on or after July 1, 2005.]

121 (i) The Commissioner of Social Services shall, to the extent
122 permitted by federal law, or, pursuant to an approved waiver of
123 federal law submitted by the commissioner, in accordance with the
124 provisions of section 17b-8, impose the following cost-sharing
125 requirements under the HUSKY Plan, on all parent and needy
126 caretaker relatives with incomes exceeding one hundred per cent of the
127 federal poverty level: (1) A twenty-five-dollar premium per month per
128 parent or needy caretaker relative; and (2) a copayment of one dollar
129 per visit for outpatient medical services delivered by an enrolled
130 Medicaid or HUSKY Plan provider. The commissioner may implement
131 policies and procedures necessary to administer the provisions of this
132 subsection while in the process of adopting such policies and
133 procedures as regulations, provided the commissioner publishes notice
134 of the intent to adopt regulations in the Connecticut Law Journal not
135 later than twenty days after implementation. Policies and procedures
136 implemented pursuant to this subsection shall be valid until the time
137 final regulations are adopted.

138 Sec. 2. Subsection (b) of section 17b-104 of the general statutes is
139 repealed and the following is substituted in lieu thereof (*Effective July*
140 *1, 2005*):

141 (b) On July 1, 1988, and annually thereafter, the commissioner shall
142 increase the payment standards over those of the previous fiscal year
143 under the aid to families with dependent children program, temporary
144 family assistance program and the state-administered general
145 assistance program by the percentage increase, if any, in the most
146 recent calendar year average in the consumer price index for urban

147 consumers over the average for the previous calendar year, provided
148 the annual increase, if any, shall not exceed five per cent, except that
149 the payment standards for the fiscal years ending June 30, 1992, June
150 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June 30, 1997, June
151 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June 30, 2002, June
152 30, 2003, June 30, 2004, [and] June 30, 2005, June 30, 2006, and June 30,
153 2007, shall not be increased. On January 1, 1994, the payment
154 standards shall be equal to the standards of need in effect July 1, 1993.

155 Sec. 3. Section 17b-7a of the general statutes is repealed and the
156 following is substituted in lieu thereof (*Effective July 1, 2005*):

157 The Commissioner of Social Services shall develop a state-wide
158 fraud early detection system. The purpose of such system shall be to
159 identify, investigate and determine if an application for assistance
160 under programs administered by the department, including, but not
161 limited to, (1) the temporary family assistance program, (2) the food
162 stamp program, (3) the child care subsidy program, or [(3)] (4) the
163 Medicaid program pursuant to Title XIX of the Social Security Act is
164 fraudulent prior to granting assistance. The commissioner shall adopt
165 regulations, in accordance with chapter 54, for the purpose of
166 developing and implementing said system. The commissioner shall
167 submit quarterly reports concerning savings realized through the
168 implementation of the state-wide fraud early detection system to the
169 joint standing committees of the General Assembly having cognizance
170 of matters relating to human services and appropriations and the
171 budgets of state agencies.

172 Sec. 4. Subsection (a) of section 17b-280 of the general statutes is
173 repealed and the following is substituted in lieu thereof (*Effective July*
174 *1, 2005*):

175 (a) The state shall reimburse for all legend drugs provided under
176 the Medicaid, state-administered general assistance, ConnPACE and
177 Connecticut AIDS drug assistance programs at the lower of (1) the rate
178 established by the [Health Care Finance Administration] Centers for

179 Medicare and Medicaid Services as the federal acquisition cost, [or , if
180 no such rate is established, the commissioner shall establish and
181 periodically revise the estimated acquisition cost in accordance with
182 federal regulations] (2) the average wholesale price minus fourteen per
183 cent, or (3) an equivalent percentage as established under the Medicaid
184 state plan. The commissioner shall also establish a professional fee of
185 three dollars and fifteen cents for each prescription to be paid to
186 licensed pharmacies for dispensing drugs to Medicaid, ConnPACE
187 and Connecticut AIDS drug assistance recipients in accordance with
188 federal regulations; and on and after September 4, 1991, payment for
189 legend and nonlegend drugs provided to Medicaid recipients shall be
190 based upon the actual package size dispensed. Effective October 1,
191 1991, reimbursement for over-the-counter drugs for such recipients
192 shall be limited to those over-the-counter drugs and products
193 published in the Connecticut Formulary, or the cross reference list,
194 issued by the commissioner. The cost of all over-the-counter drugs and
195 products provided to residents of nursing facilities, chronic disease
196 hospitals, and intermediate care facilities for the mentally retarded
197 shall be included in the facilities' per diem rate. Notwithstanding the
198 provisions of this subsection, no dispensing fee shall be issued for a
199 prescription drug dispensed to a ConnPACE or Medicaid recipient
200 who is a Medicare Part D beneficiary when the prescription drug is a
201 Medicare Part D drug, as defined in Public Law 108-173, the Medicare
202 Prescription Drug, Improvement, and Modernization Act of 2003.

203 Sec. 5. Subsection (h) of section 17b-292 of the general statutes is
204 repealed and the following is substituted in lieu thereof (*Effective July*
205 *1, 2005*):

206 (h) Not more than twelve months after the determination of
207 eligibility for benefits under the HUSKY Plan, Part A and Part B and
208 annually thereafter, the commissioner or the servicer, as the case may
209 be, shall determine if the child continues to be eligible for the plan. The
210 commissioner or the servicer shall mail an application form to each
211 participant in the plan for the purposes of obtaining information to
212 make a determination on eligibility. [To the extent permitted by federal

213 law, in determining eligibility for benefits under the HUSKY Plan, Part
214 A and Part B with respect to family income, the commissioner or the
215 servicer shall rely upon information provided in such form by the
216 participant unless the commissioner or the servicer has reason to
217 believe that such information is inaccurate or incomplete.] The
218 determination of eligibility shall be coordinated with health plan open
219 enrollment periods.

220 Sec. 6. Subsection (g) of section 17b-239 of the general statutes is
221 repealed and the following is substituted in lieu thereof (*Effective July*
222 *1, 2005*):

223 (g) Effective June 1, 2001, the commissioner shall establish inpatient
224 hospital rates in accordance with the method specified in regulations
225 adopted pursuant to this section and applied for the rate period
226 beginning October 1, 2000, except that the commissioner shall update
227 each hospital's target amount per discharge to the actual allowable cost
228 per discharge based upon the 1999 cost report filing multiplied by
229 sixty-two and one-half per cent if such amount is higher than the target
230 amount per discharge for the rate period beginning October 1, 2000, as
231 adjusted for the ten per cent incentive identified in Section 4005 of
232 Public Law 101-508. If a hospital's rate is increased pursuant to this
233 subsection, the hospital shall not receive the ten per cent incentive
234 identified in Section 4005 of Public Law 101-508. For rate periods
235 beginning October 1, 2001, through March 31, 2008, the commissioner
236 shall not apply an annual adjustment factor to the target amount per
237 discharge. Effective April 1, 2005, the revised target amount per
238 discharge for each hospital with a target amount per discharge less
239 than three thousand seven hundred fifty dollars shall be three
240 thousand seven hundred fifty dollars. Effective [April] October 1, 2006,
241 the revised target amount per discharge for each hospital with a target
242 amount per discharge less than four thousand dollars shall be four
243 thousand dollars. Effective [April] October 1, 2007, the revised target
244 amount per discharge for each hospital with a target amount per
245 discharge less than four thousand two hundred fifty dollars shall be
246 four thousand two hundred fifty dollars.

247 Sec. 7. Section 17b-295 of the general statutes is repealed and the
248 following is substituted in lieu thereof (*Effective July 1, 2005*):

249 (a) The commissioner shall impose cost-sharing requirements
250 including the payment of a premium or copayment in connection with
251 services provided under the HUSKY Plan, Part B, to the extent
252 permitted by federal law, and in accordance with the following
253 limitations:

254 (1) On and after [October 1, 2003] July 1, 2005, the commissioner
255 [may] shall increase the maximum annual aggregate cost-sharing
256 requirements provided that such cost-sharing requirements shall not
257 exceed five per cent of the family's gross annual income. The
258 commissioner [may] shall, as a component of the family's cost-sharing
259 responsibility, provided the family's annual combined premiums and
260 copayments do not exceed the maximum annual aggregate cost-
261 sharing requirement, (A) impose a premium requirement on families,
262 whose income exceeds one hundred eighty-five per cent of the federal
263 poverty level [as a component of the family's cost-sharing
264 responsibility provided the family's annual combined premiums and
265 copayments do not exceed the maximum annual aggregate cost-
266 sharing requirement] but does not exceed two hundred thirty-five per
267 cent of the federal poverty level; and (B) increase the premium
268 requirement on families whose income exceeds two hundred thirty-
269 five per cent of the federal poverty level, but does not exceed three
270 hundred per cent of the federal poverty level; and

271 (2) The commissioner shall require each managed care plan to
272 monitor copayments and premiums under the provisions of
273 subdivision (1) of this subsection.

274 (b) (1) Except as provided in subdivision (2) of this subsection, the
275 commissioner may impose limitations on the amount, duration and
276 scope of benefits under the HUSKY Plan, Part B.

277 (2) The limitations adopted by the commissioner pursuant to
278 subdivision (1) of this subsection shall not preclude coverage of any

279 item of durable medical equipment or service that is medically
280 necessary.

281 Sec. 8. Section 17b-277 of the general statutes is repealed and the
282 following is substituted in lieu thereof (*Effective July 1, 2005*):

283 (a) The Commissioner of Social Services shall provide, in accordance
284 with federal law and regulations, medical assistance under the
285 Medicaid program to needy pregnant women and children up to one
286 year of age whose families have an income up to one hundred eighty-
287 five per cent of the federal poverty level.

288 (b) The commissioner shall [implement presumptive] expedite
289 eligibility for appropriate pregnant women applicants for the Medicaid
290 program. [with an emphasis on pregnant women. Such presumptive
291 eligibility determinations shall be in accordance with applicable
292 federal law and regulations. The commissioner shall provide such
293 presumptive eligibility determinations on a pilot basis, in one district
294 office, beginning June 1, 1991, and shall provide them state-wide
295 effective September 1, 1991.] The process for making expedited
296 eligibility determinations concerning needy pregnant women shall
297 ensure that emergency applications for assistance, as determined by
298 the commissioner, shall be processed no later than twenty-four hours
299 after receipt of all required information from the applicant, and that
300 nonemergency applications for assistance, as determined by the
301 commissioner, shall be processed no later than five calendar days after
302 the date of receipt of all required information from the applicant.

303 (c) The commissioner shall submit biannual reports to the council,
304 established pursuant to section 17b-28, on the department's compliance
305 with the administrative processing requirements set forth in subsection
306 (b) of this section.

307 Sec. 9. Section 17b-292 of the general statutes is repealed and the
308 following is substituted in lieu thereof (*Effective July 1, 2005*):

309 (a) A child who resides in a household with a family income which

310 exceeds one hundred eighty-five per cent of the federal poverty level
311 and does not exceed three hundred per cent of the federal poverty
312 level may be eligible for subsidized benefits under the HUSKY Plan,
313 Part B. [The services and cost-sharing requirements under the HUSKY
314 Plan, Part B shall be substantially similar to the services and cost-
315 sharing requirements of the largest commercially available health plan
316 offered by a managed care organization, as defined in section 38a-478,
317 offered to residents in this state as measured by the number of covered
318 lives reported to the Insurance Department in the most recent audited
319 annual report.]

320 (b) A child who resides in a household with a family income over
321 three hundred per cent of the federal poverty level may be eligible for
322 unsubsidized benefits under the HUSKY Plan, Part B.

323 (c) Whenever a court or family support magistrate orders a
324 noncustodial parent to provide health insurance for a child, such
325 parent may provide for coverage under the HUSKY Plan, Part B.

326 (d) To the extent allowed under federal law, the commissioner shall
327 not pay for services or durable medical equipment under the HUSKY
328 Plan, Part B if the enrollee has other insurance coverage for the services
329 or such equipment.

330 (e) A newborn child who otherwise meets the eligibility criteria for
331 the HUSKY Plan, Part B shall be eligible for benefits retroactive to his
332 date of birth, provided an application is filed on behalf of the child
333 within thirty days of such date.

334 (f) The commissioner shall implement presumptive eligibility for
335 children applying for Medicaid. Such presumptive eligibility
336 determinations shall be in accordance with applicable federal law and
337 regulations. The commissioner shall adopt regulations, in accordance
338 with chapter 54, to establish standards and procedures for the
339 designation of organizations as qualified entities to grant presumptive
340 eligibility. Qualified entities shall ensure that, at the time a
341 presumptive eligibility determination is made, a completed application

342 for Medicaid is submitted to the department for a full eligibility
343 determination. In establishing such standards and procedures, the
344 commissioner shall ensure the representation of state-wide and local
345 organizations that provide services to children of all ages in each
346 region of the state.

347 ~~[(f)]~~ (g) The commissioner shall enter into a contract with an entity
348 to be a single point of entry servicer for applicants and enrollees under
349 the HUSKY Plan, Part A and Part B. The servicer shall jointly market
350 both Part A and Part B together as the HUSKY Plan. Such servicer shall
351 develop and implement public information and outreach activities
352 with community programs. Such servicer shall electronically transmit
353 data with respect to enrollment and disenrollment in the HUSKY Plan,
354 Part B to the commissioner.

355 (h) Upon the expiration of any contractual provisions entered into
356 pursuant to subsection (g) of this section, the commissioner shall
357 develop a new contract for single point of entry services and managed
358 care enrollment brokerage services. The commissioner may enter into
359 one or more contractual arrangements for such services for a contract
360 period not to exceed seven years. Such contracts shall include
361 performance measures, including, but not limited to, specified time
362 limits for the processing of applications, parameters setting forth the
363 requirements for a completed and reviewable application and the
364 percentage of applications forwarded to the department in a complete
365 and timely fashion. Such contracts shall also include a process for
366 identifying and correcting noncompliance with established
367 performance measures, including sanctions applicable for instances of
368 continued noncompliance with performance measures.

369 ~~[(g)]~~ (i) The single point of entry servicer shall send an application
370 and supporting documents to the commissioner for determination of
371 eligibility of a child who resides in a household with a family income
372 of one hundred eighty-five per cent or less of the federal poverty level.
373 The servicer shall enroll eligible beneficiaries in the applicant's choice
374 of managed care plan. Upon enrollment in a managed care plan, an

375 eligible Husky Plan Part A or Part B beneficiary shall remain enrolled
376 in such managed care plan for twelve months from the date of such
377 enrollment unless (1) an eligible beneficiary demonstrates good cause
378 to the satisfaction of the commissioner of the need to enroll in a
379 different managed care plan, or (2) the beneficiary no longer meets
380 program eligibility requirements.

381 ~~[(h)]~~ [(j)] Not more than twelve months after the determination of
382 eligibility for benefits under the HUSKY Plan, Part A and Part B and
383 annually thereafter, the commissioner or the servicer, as the case may
384 be, shall determine if the child continues to be eligible for the plan. The
385 commissioner or the servicer shall mail an application form to each
386 participant in the plan for the purposes of obtaining information to
387 make a determination on eligibility. To the extent permitted by federal
388 law, in determining eligibility for benefits under the HUSKY Plan, Part
389 A and Part B with respect to family income, the commissioner or the
390 servicer shall rely upon information provided in such form by the
391 participant unless the commissioner or the servicer has reason to
392 believe that such information is inaccurate or incomplete. The
393 determination of eligibility shall be coordinated with health plan open
394 enrollment periods.

395 ~~[(i)]~~ [(k)] The commissioner shall implement the HUSKY Plan, Part B
396 while in the process of adopting necessary policies and procedures in
397 regulation form in accordance with the provisions of section 17b-10.

398 ~~[(j)]~~ [(l)] The commissioner shall adopt regulations, in accordance
399 with chapter 54, to establish residency requirements and income
400 eligibility for participation in the HUSKY Plan, Part B and procedures
401 for a simplified mail-in application process. Notwithstanding the
402 provisions of section 17b-257b, such regulations shall provide that any
403 child adopted from another country by an individual who is a citizen
404 of the United States and a resident of this state shall be eligible for
405 benefits under the HUSKY Plan, Part B upon arrival in this state.

406 Sec. 10. Subsection (i) of section 17b-342 of the general statutes is

407 repealed and the following is substituted in lieu thereof (*Effective July*
408 *1, 2005*):

409 (i) (1) On and after July 1, 1992, the Commissioner of Social Services
410 shall, within available appropriations, administer a state-funded
411 portion of the program for persons (A) who are sixty-five years of age
412 and older; (B) who are inappropriately institutionalized or at risk of
413 inappropriate institutionalization; (C) whose income is less than or
414 equal to the amount allowed under subdivision (3) of subsection (a) of
415 this section; and (D) whose assets, if single, do not exceed the
416 minimum community spouse protected amount pursuant to Section
417 4022.05 of the department's uniform policy manual or, if married, the
418 couple's assets do not exceed one hundred fifty per cent of said
419 community spouse protected amount and on and after April 1, 2007,
420 whose assets, if single, do not exceed one hundred fifty per cent of the
421 minimum community spouse protected amount pursuant to Section
422 4022.05 of the department's uniform policy manual or, if married, the
423 couple's assets do not exceed two hundred per cent of said community
424 spouse protected amount.

425 (2) Any person whose income exceeds two hundred per cent of the
426 federal poverty level shall contribute to the cost of care in accordance
427 with the methodology established for recipients of medical assistance
428 pursuant to Sections 5035.20 and 5035.25 of the department's uniform
429 policy manual.

430 (3) On and after June 30, 1992, the program shall serve persons
431 receiving state-funded home and community-based services from the
432 department, persons receiving services under the promotion of
433 independent living for the elderly program operated by the
434 Department of Social Services, regardless of age, and persons receiving
435 services on June 19, 1992, under the home care demonstration project
436 operated by the Department of Social Services. Such persons receiving
437 state-funded services whose income and assets exceed the limits
438 established pursuant to subdivision (1) of this subsection may continue
439 to participate in the program, but shall be required to pay the total cost

440 of care, including case management costs.

441 (4) Services shall not be increased for persons who received services
442 under the promotion of independent living for the elderly program
443 over the limits in effect under said program in the fiscal year ending
444 June 30, 1992, unless a person's needs increase and the person is
445 eligible for Medicaid.

446 (5) The annualized cost of services provided to an individual under
447 the state-funded portion of the program shall not exceed fifty per cent
448 of the weighted average cost of care in nursing homes in the state,
449 except an individual who received services costing in excess of such
450 amount under the Department of Social Services in the fiscal year
451 ending June 30, 1992, may continue to receive such services, provided
452 the annualized cost of such services does not exceed eighty per cent of
453 the weighted average cost of such nursing home care. The
454 commissioner may allow the cost of services provided to an individual
455 to exceed the maximum cost established pursuant to this subdivision
456 in a case of extreme hardship, as determined by the commissioner,
457 provided in no case shall such cost exceed that of the weighted cost of
458 such nursing home care.

459 Sec. 11. (NEW) (*Effective July 1, 2005*) The Commissioner of Social
460 Services shall develop and implement a two-year pilot program for up
461 to one hundred individuals who: (1) Are ages nineteen to twenty-one;
462 (2) reside with a parent or a relative caregiver; (3) have been diagnosed
463 with one or more mental disorders as defined in the most recent
464 edition of the American Psychiatric Association's "Diagnostic and
465 Statistical Manual of Mental Disorders"; (4) have a significant chronic
466 health condition, (5) have a substantial functional impairment as a
467 result of the mental disorder or chronic health condition, and (6) are
468 ineligible for medical assistance under the state-administered general
469 assistance program due to parent or relative caregiver income. An
470 individual who is eligible for benefits under this program, shall
471 cooperate in establishing such individual's eligibility for Medicaid
472 coverage based on disability. For purposes of this section "mental

473 disorder" shall not include mental retardation, learning disorders,
474 motor skill disorder, communication disorders, caffeine-related
475 disorders, relational problems and additional conditions that may be a
476 focus of clinical attention that are not otherwise defined as mental
477 disorders in the most recent edition of the American Psychiatric
478 Association's "Diagnostic and Statistical Manual of Mental Disorders".

479 Sec. 12. Subsection (a) of section 16a-46 of the general statutes is
480 repealed and the following is substituted in lieu thereof (*Effective July*
481 *1, 2005*):

482 (a) The Secretary of the Office of Policy and Management shall be
483 responsible for the development and implementation of a residential
484 energy conservation service program in accordance with the
485 provisions of this section, sections 16a-46a, 16a-46b and 16a-46c and
486 applicable federal law. Participants in the program shall provide or
487 arrange for low cost energy audits. No participant under subdivision
488 (1) or (3) of section 16a-45a may be required to provide such services
489 outside its authorized service area or area of normal operation. The
490 residential energy conservation service program shall terminate on
491 July 1, [2005] 2010.

492 Sec. 13. Subsection (c) of section 17b-192 of the general statutes is
493 repealed and the following is substituted in lieu thereof (*Effective July*
494 *1, 2005*):

495 (c) On and after October 1, 2003, pharmacy services shall be
496 provided to recipients of state-administered general assistance through
497 the federally qualified health center to which they are assigned or
498 through a pharmacy with which the health center contracts. Prior to
499 said date, pharmacy services shall be provided as provided under the
500 Medicaid program. Recipients who are assigned to a community
501 health center or similar clinic or primary care provider other than a
502 federally qualified health center or to a federally qualified health
503 center that does not have a contract for pharmacy services shall receive
504 pharmacy services at pharmacies designated by the commissioner. The

505 Commissioner of Social Services or the managed care organization or
506 other entity performing administrative functions for the program as
507 permitted in subsection (d) of this section, shall require prior
508 authorization for coverage of drugs for the treatment of erectile
509 dysfunction. The commissioner or the managed care organization or
510 other entity performing administrative functions for the program may
511 limit or exclude coverage for drugs for the treatment of erectile
512 dysfunction for persons who have been convicted of a sexual offense
513 who are required to register with the Commissioner of Public Safety
514 pursuant to chapter 969.

515 Sec. 14. Subsection (b) of section 17b-490 of the general statutes is
516 repealed and the following is substituted in lieu thereof (*Effective July*
517 *1, 2005*):

518 (b) "Prescription drugs" means (1) legend drugs, as defined in
519 section 20-571, (2) any other drugs which by state law or regulation
520 require the prescription of a licensed practitioner for dispensing,
521 except: (A) [products] Products prescribed for cosmetic purposes as
522 specified in regulations adopted pursuant to section 17b-494; [, and]
523 (B) on and after September 15, 1991, diet pills, smoking cessation gum,
524 contraceptives, multivitamin combinations, cough preparations and
525 antihistamines; [,] and (C) drugs for the treatment of erectile
526 dysfunction for persons who have been convicted of a sexual offense
527 who are required to register with the Commissioner of Public Safety
528 pursuant to chapter 969; and (3) insulin [,] and insulin syringes. [and
529 insulin needles;]

530 Sec. 15. Section 17b-279 of the general statutes is repealed and the
531 following is substituted in lieu thereof (*Effective July 1, 2005*):

532 The Commissioner of Social Services shall verify the propriety and
533 reasonableness of payments to providers for drugs provided to
534 Medicaid recipients through field audit examinations and other
535 reasonable means to the extent possible within available
536 appropriations. To the extent permitted by federal law, the

537 commissioner shall require prior authorization for coverage of drugs
538 for the treatment of erectile dysfunction. To the extent permitted by
539 federal law, the commissioner may limit or exclude coverage for drugs
540 for the treatment of erectile dysfunction for persons who have been
541 convicted of a sexual offense who are required to register with the
542 Commissioner of Public Safety pursuant to chapter 969. The
543 commissioner shall document financial and utilization statistics as to
544 drugs provided to Medicaid recipients by therapeutic category and
545 shall outline problems encountered in the administration of
546 prescription drug utilization in the Medicaid program, suggested
547 solutions and any recommendations for improvement.

548 Sec. 16. Subsection (c) of section 17b-274 of the general statutes is
549 repealed and the following is substituted in lieu thereof (*Effective July*
550 *1, 2005*):

551 (c) The Commissioner of Social Services shall implement a
552 procedure by which a pharmacist shall obtain approval from an
553 independent pharmacy consultant acting on behalf of the Department
554 of Social Services, under an administrative services only contract,
555 whenever the pharmacist dispenses a brand name drug product to a
556 Medicaid, state-administered general assistance, or ConnPACE
557 recipient and a chemically equivalent generic drug product
558 substitution is available. [provided such procedure shall not require
559 approval for other than initial prescriptions for such drug product.]
560 The length of authorization for brand name drugs shall be in
561 accordance with section 17b-491a, as amended by this act. In cases
562 where the brand name drug is less costly than the chemically
563 equivalent generic drug when factoring in manufacturers' rebates, the
564 pharmacist shall dispense the brand name drug. If such approval is not
565 granted or denied within two hours of receipt by the commissioner of
566 the request for approval, it shall be deemed granted. Notwithstanding
567 any provision of this section, a pharmacist shall not dispense any
568 initial maintenance drug prescription for which there is a chemically
569 equivalent generic substitution that is for less than fifteen days without
570 the department's granting of prior authorization, provided prior

571 authorization shall not otherwise be required for atypical antipsychotic
572 drugs if the individual is currently taking such drug at the time the
573 pharmacist receives the prescription. The pharmacist may appeal a
574 denial of reimbursement to the department based on the failure of
575 such pharmacist to substitute a generic drug product in accordance
576 with this section.

577 Sec. 17. Section 17b-491a of the general statutes is repealed and the
578 following is substituted in lieu thereof (*Effective from passage*):

579 (a) The Commissioner of Social Services may [establish a plan for
580 the] require prior authorization of [(1)] any [initial] prescription for a
581 drug covered under the Medicaid, state-administered general
582 assistance, or ConnPACE program, [that costs five hundred dollars or
583 more for a thirty-day supply, or (2)] including (1) any early refill of a
584 prescription drug covered under any of said programs; and (2) brand
585 name drug products when a chemically equivalent generic drug
586 product substitution is available. The authorization for a brand name
587 drug product shall be valid for one year from the date the prescription
588 is first filled. The Commissioner of Social Services shall establish a
589 procedure by which prior authorization under this subsection shall be
590 obtained from an independent pharmacy consultant acting on behalf
591 of the Department of Social Services, under an administrative services
592 only contract. If prior authorization is not granted or denied within
593 two hours of receipt by the commissioner of the request for prior
594 authorization, it shall be deemed granted.

595 (b) The Commissioner of Social Services, [shall,] to increase cost-
596 efficiency or enhance access to a particular prescription drug, [establish
597 a plan under which the commissioner] may designate specific
598 suppliers of a prescription drug from which a dispensing pharmacy
599 shall order the prescription to be delivered to the pharmacy and billed
600 by the supplier to the department. For each prescription dispensed
601 through designated suppliers, the department shall pay the dispensing
602 pharmacy a handling fee not to exceed four hundred per cent of the
603 dispensing fee established pursuant to section 17b-280. In no event

604 shall the provisions of this subsection be construed to allow the
605 commissioner to purchase all prescription drugs covered under the
606 Medicaid, state-administered general assistance, and ConnPACE
607 programs under one contract.

608 (c) Notwithstanding the provisions of section 17b-262 and any
609 regulation adopted thereunder, on or after July 1, 2000, the
610 Commissioner of Social Services may establish a schedule of maximum
611 quantities of oral dosage units permitted to be dispensed at one time
612 for prescriptions covered under the Medicaid and state-administered
613 general assistance programs based on a review of utilization patterns.

614 (d) A plan or schedule established pursuant to subsection (a), (b) or
615 (c) of this section and on and after July 1, 2005, any revisions thereto
616 shall be submitted to the joint standing committees of the General
617 Assembly having cognizance of matters relating to public health,
618 human services and appropriations and the budgets of state agencies.
619 Within sixty days of receipt of such a plan or schedule or revisions
620 thereto, said joint standing committees of the General Assembly shall
621 approve or deny the plan or schedule or any revisions thereto and
622 advise the commissioner of their approval or denial of the plan or
623 schedule or any revisions thereto. The plan or schedule or any
624 revisions thereto shall be deemed approved unless all committees vote
625 to reject such plan or schedule or revisions thereto within sixty days of
626 receipt of such plan or schedule or revisions thereto.

627 Sec. 18. Section 17b-274d of the general statutes is repealed and the
628 following is substituted in lieu thereof (*Effective July 1, 2005*):

629 (a) Pursuant to 42 USC 1396r-8, there is established a [Medicaid]
630 Pharmaceutical and Therapeutics Committee within the Department of
631 Social Services.

632 (b) The [Medicaid] Pharmaceutical and Therapeutics Committee
633 shall be comprised as specified in 42 USC 1396r-8 and shall consist of
634 fourteen members appointed by the Governor. Five members shall be
635 physicians licensed pursuant to chapter 370, including one general

636 practitioner, one pediatrician, one geriatrician, one psychiatrist and
637 one specialist in family planning, four members shall be pharmacists
638 licensed pursuant to chapter 400j, two members shall be visiting
639 nurses, one specializing in adult care and one specializing in
640 psychiatric care, one member shall be a clinician designated by the
641 Commissioner of Mental Health and Addiction Services, one member
642 shall be a representative of pharmaceutical manufacturers and one
643 member shall be a consumer representative. The committee may, on an
644 ad hoc basis, seek the participation of other state agencies or other
645 interested parties in its deliberations. The members shall serve for
646 terms of two years from the date of their appointment. Members may
647 be appointed to more than one term. The Commissioner of Social
648 Services, or the commissioner's designee, shall convene the committee
649 following the Governor's designation of appointments. The
650 administrative staff of the Department of Social Services shall serve as
651 staff for said committee and assist with all ministerial duties. The
652 Governor shall ensure that the committee membership includes
653 Medicaid participating physicians and pharmacists, with experience
654 serving [all segments of the Medicaid population] recipients of medical
655 assistance.

656 (c) Committee members shall select a chairperson and vice-
657 chairperson from the committee membership on an annual basis.

658 (d) The committee shall meet at least quarterly, and may meet at
659 other times at the discretion of the chairperson and committee
660 membership. The committee shall comply with all regulations adopted
661 by the department, including notice of any meeting of the committee,
662 pursuant to the requirements of chapter 54.

663 (e) The Department of Social Services, in consultation with the
664 [Medicaid] Pharmaceutical and Therapeutics Committee, [shall] may
665 adopt preferred drug lists for use in the Medicaid, state-administered
666 general assistance and ConnPACE programs. The Department of
667 Social Services, upon entering into a contract for the provision of
668 prescription drug coverage to medical assistance recipients receiving

669 services in a managed care setting as provided by section 17b-266a,
670 shall in consultation with the [Medicaid] Pharmaceutical and
671 Therapeutics Committee, expand the preferred drug list for use in the
672 HUSKY Plan, Part A and Part B. To the extent feasible, the department
673 shall review all drugs included on the preferred drug lists at least
674 every twelve months, and may recommend additions to, and deletions
675 from, the preferred drug lists, to ensure that the preferred drug lists
676 provide for medically appropriate drug therapies for Medicaid, state-
677 administered general assistance and ConnPACE patients. For the fiscal
678 year ending June 30, 2004, such drug lists shall be limited to use in the
679 Medicaid and ConnPACE programs and cover three classes of drugs,
680 including proton pump inhibitors and two other classes of drugs
681 determined by the Commissioner of Social Services. Not later than
682 June 30, 2005, the Department of Social Services, in consultation with
683 the [Medicaid] Pharmaceutical and Therapeutic Committee shall
684 expand such drug lists to include other classes of drugs, except as
685 provided in subsection (f) of this section, in order to achieve savings
686 reflected in the amounts appropriated to the department, for the
687 various components of the program, in the state budget act.

688 (f) [Except for mental-health-related drugs] Nonpreferred drugs in
689 the classes of drugs included on the preferred drug lists shall be
690 subject to prior authorization. If prior authorization is granted for a
691 drug not included on a preferred drug list, the authorization shall be
692 valid for one year from the date the prescription is first filled. Mental
693 health related and antiretroviral classes of drugs [reimbursement for a
694 drug not included on the preferred drug lists are subject to prior
695 authorization] shall not be included on the preferred drug lists.

696 (g) The Department of Social Services shall publish and disseminate
697 the preferred drug lists to all Medicaid providers in the state.

698 (h) The department may negotiate supplemental rebate agreements
699 with manufacturers that are in addition to those required under Title
700 XIX of the Social Security Act. The committee shall ensure that the
701 pharmaceutical manufacturers agreeing to provide a supplemental

702 rebate pursuant to 42 USC 1396r-8(c) have an opportunity to present
703 evidence supporting inclusion of a product on the preferred drug lists
704 unless a court of competent jurisdiction, in a final decision, determines
705 that the Secretary of Health and Human Services does not have
706 authority to allow such supplemental rebates, provided the inability to
707 utilize supplemental rebates pursuant to this subsection shall not
708 impair the committee's authority to maintain preferred drug lists.
709 Upon timely notice, the department shall ensure that any drug that has
710 been approved, or had any of its particular uses approved, by the
711 United States Food and Drug Administration under a priority review
712 classification, will be reviewed by the [Medicaid] Pharmaceutical and
713 Therapeutics Committee at the next regularly scheduled meeting. To
714 the extent feasible, upon notice by a pharmaceutical manufacturer, the
715 department shall also schedule a product review for any new product
716 at the next regularly scheduled meeting of the [Medicaid]
717 Pharmaceutical and Therapeutics Committee.

718 (i) Factors considered by the department and the [Medicaid]
719 Pharmaceutical and Therapeutics Committee in developing the
720 preferred drug lists shall include, but not be limited to, clinical
721 efficacy, safety and cost effectiveness of a product.

722 (j) The [Medicaid] Pharmaceutical and Therapeutics Committee may
723 also make recommendations to the department regarding the prior
724 authorization of any prescribed drug. [covered by Medicaid in
725 accordance with the plan developed and implemented pursuant to
726 section 17b-491a.]

727 [(k) Medicaid recipients may appeal any department preferred drug
728 list determinations utilizing the Medicaid fair hearing process
729 administered by the Department of Social Services established
730 pursuant to chapter 54.]

731 (k) A recipient who is denied a nonpreferred drug may request an
732 administrative hearing in accordance with section 17b-60.

733 (l) The Commissioner of Social Services may contract with a

734 pharmacy benefits organization or a single entity qualified to negotiate
735 with pharmaceutical manufacturers for supplemental rebates,
736 available pursuant to 42 USC 1396r-8(c), for the purchase of drugs
737 listed on the preferred drug lists established pursuant to subsection (e)
738 of this section.

739 Sec. 19. (NEW) (*Effective July 1, 2005*) On and after the effective date
740 of the Medicare Part D program established pursuant to Public Law
741 108-173, the Medicare Prescription Drug, Improvement, and
742 Modernization Act of 2003, no Medicaid prescription drug coverage
743 shall be provided to a Medicaid recipient eligible for Medicare Part D
744 for Medicare Part D Drugs, as defined in said act. Medicaid coverage
745 will be provided for prescription drugs that are not Medicare Part D
746 drugs, as defined in said act.

747 Sec. 20. Section 17b-490 of the general statutes is repealed and the
748 following is substituted in lieu thereof (*Effective July 1, 2005*):

749 As used in sections 17b-490 to 17b-498, inclusive:

750 (a) "Pharmacy" means a pharmacy licensed under section 20-594 or
751 a pharmacy located in a health care institution, as defined in
752 subsection (a) of section 19a-490, which elects to participate in the
753 program;

754 (b) "Prescription drugs" means (1) legend drugs, as defined in
755 section 20-571, (2) any other drugs which by state law or regulation
756 require the prescription of a licensed practitioner for dispensing,
757 except products prescribed for cosmetic purposes as specified in
758 regulations adopted pursuant to section 17b-494, and on and after
759 September 15, 1991, diet pills, smoking cessation gum, contraceptives,
760 multivitamin combinations, cough preparations and antihistamines,
761 and (3) insulin [,] and insulin syringes; [and insulin needles;]

762 (c) "Reasonable cost" means the cost of the prescription drug
763 determined in accordance with the formula adopted by the
764 Commissioner of Social Services in regulations for medical assistance

765 purposes plus a dispensing fee equal to the fee determined by said
766 commissioner for medical assistance purposes;

767 (d) "Resident" means a person legally domiciled within the state for
768 a period of not less than one hundred eighty-three days immediately
769 preceding the date of application for inclusion in the program. Mere
770 seasonal or temporary residences within the state, of whatever
771 duration, shall not constitute domicile;

772 (e) "Disabled" means a person over eighteen years of age who is
773 receiving disability payments pursuant to either Title 2 or Title 16 of
774 the Social Security Act of 1935, as amended;

775 (f) "Commissioner" means the Commissioner of Social Services;

776 (g) "Income" means adjusted gross income as determined for
777 purposes of the federal income tax plus any other income of such
778 person not included in such adjusted gross income minus Medicare
779 Part B premium payments. The amount of any Medicaid payments
780 made on behalf of such person or the spouse of such person shall not
781 constitute income;

782 (h) "Program" means the Connecticut [pharmaceutical assistance
783 contract to the elderly and the disabled program] Pharmaceutical
784 Assistance Contract to the Elderly and the Disabled Program otherwise
785 known as ConnPACE;

786 (i) "Pharmaceutical manufacturer" means any entity holding legal
787 title to or possession of a national drug code number issued by the
788 federal Food and Drug Administration;

789 (j) "Average manufacturer price" means the average price paid by a
790 wholesaler to a pharmaceutical manufacturer, after the deduction of
791 any customary prompt payment discounts, for a product distributed
792 for retail sale;

793 (k) "Assets" means a person's resources, as defined by Public Law
794 108-173, the Medicare Prescription Drug, Improvement, and

795 Modernization Act of 2003;

796 (l) "Low income subsidy" means a premium and cost-sharing
797 subsidy for low-income individuals, as defined by Public Law 108-173,
798 the Medicare Prescription Drug, Improvement, and Modernization Act
799 of 2003;

800 (m) "Medicare Part D covered prescription drugs" means drugs that
801 are included in Medicare Part D plan's formulary or are treated as
802 being included in a Medicare Part D plan's formulary, as defined by
803 Public Law 108-173, the Medicare Prescription Drug, Improvement
804 and Modernization Act of 2003;

805 (n) "Medicare Part D plan" means a Medicare Part D plan, as
806 defined by Public Law 108-173, the Medicare Prescription Drug,
807 Improvement, and Modernization Act of 2003;

808 (o) "Gap in standard Medicare Part D coverage" means a drug
809 obtained after a Medicare Part D beneficiary's initial coverage limit has
810 been exceeded but before the beneficiary's annual out-of-pocket
811 threshold has been met, as defined by Public Law 108-173, the
812 Medicare Prescription Drug, Improvement, and Modernization Act of
813 2003.

814 Sec. 21. Subsection (a) of section 17b-491 of the general statutes is
815 repealed and the following is substituted in lieu thereof (*Effective July*
816 *1, 2005*):

817 (a) There shall be a "Connecticut Pharmaceutical Assistance
818 Contract to the Elderly and the Disabled Program" which shall be
819 within the Department of Social Services. The program shall consist of
820 payments by the state to pharmacies for the reasonable cost of
821 prescription drugs dispensed to eligible persons minus a copayment
822 charge. The pharmacy shall collect the copayment charge from the
823 eligible person at the time of each purchase of prescription drugs, and
824 shall not waive, discount or rebate in whole or in part such amount.
825 [Except for a replacement prescription dispensed pursuant to section

826 17b-492, the] The copayment for each prescription shall [be as follows:]
827 not exceed sixteen dollars and twenty-five cents.

828 [(1) Sixteen dollars and twenty-five cents if the participant is (A) not
829 married and has an annual income of less than twenty thousand three
830 hundred dollars, or (B) married and has an annual income that, when
831 combined with the participant's spouse, is less than twenty-seven
832 thousand five hundred dollars.

833 (2) Upon the granting of a federal waiver to expand the program in
834 accordance with section 17b-492, the copayment shall be twenty
835 dollars for a participant who is (A) not married and has an annual
836 income that equals or exceeds twenty thousand three hundred dollars,
837 or (B) married and has an annual income that, when combined with
838 the participant's spouse, equals or exceeds twenty-seven thousand five
839 hundred dollars.]

840 Sec. 22. Section 17b-492 of the general statutes is repealed and the
841 following is substituted in lieu thereof (*Effective July 1, 2005*):

842 (a) Eligibility for participation in the program shall be limited to any
843 resident (1) who is sixty-five years of age or older or who is disabled,
844 (2) whose current annual income at the time of application or
845 redetermination, if unmarried, is less than twenty thousand eight
846 hundred dollars or whose annual income, if married, when combined
847 with that of the resident's spouse is less than twenty-eight thousand
848 one hundred dollars, (3) who is not insured under a policy which
849 provides full or partial coverage for prescription drugs once a
850 deductible is met, except for a Medicare prescription drug discount
851 card endorsed by the Secretary of Health and Human Services in
852 accordance with Public Law 108-173, the Medicare Prescription Drug,
853 Improvement, and Modernization Act of 2003, [once a deductible
854 amount is met] or coverage under Medicare Part D pursuant to said
855 act, and (4) on and after September 15, 1991, who pays an annual
856 thirty-dollar registration fee to the Department of Social Services.
857 [Effective January 1, 2002, the commissioner shall commence accepting

858 applications from individuals who will become eligible to participate
859 in the program as of April 1, 2002.] On January 1, 1998, and annually
860 thereafter, the commissioner shall increase the income limits
861 established under this subsection over those of the previous fiscal year
862 to reflect the annual inflation adjustment in Social Security income, if
863 any. Each such adjustment shall be determined to the nearest one
864 hundred dollars.

865 (b) (1) Payment for a prescription under the program shall be made
866 only if no other plan of insurance or assistance is available to an
867 eligible person for such prescription at the time of dispensing, except
868 for benefits received from an endorsed Medicare prescription drug
869 discount card or benefits provided under Medicare Part D. The
870 pharmacy shall make reasonable efforts to ascertain the existence of
871 other insurance or assistance, including the subsidy provided by an
872 endorsed Medicare prescription drug discount card or benefits
873 provided under Medicare Part D. A Medicare prescription drug
874 discount card beneficiary shall be responsible for the payment of any
875 Medicare prescription drug discount card coinsurance requirements,
876 provided such requirements do not exceed the ConnPACE program
877 copayment requirements. If a Medicare prescription drug discount
878 card beneficiary's coinsurance requirements exceed the ConnPACE
879 copayment requirements, the Department of Social Services shall make
880 payment to the pharmacy to cover costs in excess of the ConnPACE
881 copayment amount. If the cost to such beneficiary exceeds the
882 remaining available Medicare prescription drug discount card subsidy,
883 the beneficiary shall not be responsible for any payment in excess of
884 the amount of the ConnPACE program copayment requirement. In
885 such cases, the Department of Social Services shall make payment to
886 the pharmacy to cover costs in excess of the ConnPACE copayment
887 amount.

888 (2) A Medicare Part D beneficiary shall be responsible for the
889 payment of Medicare Part D copayments, coinsurance and deductible
890 requirements for Medicare Part D covered prescription drugs, as
891 defined in Public Law 108-173, the Medicare Prescription Drug,

892 Improvement, and Modernization Act of 2003, to the extent such
893 requirements do not exceed the ConnPACE program copayment
894 requirements. The Department of Social Services shall pay Medicare
895 Part D monthly beneficiary premiums on behalf of the beneficiary. If a
896 Medicare Part D beneficiary's out-of-pocket copayment, coinsurance or
897 deductible requirements exceed the ConnPACE copayment
898 requirements, the department shall make payment to the pharmacy to
899 cover costs in excess of the ConnPACE copayment amount. The
900 department shall be responsible for payment of a Medicare Part D
901 covered prescription drug obtained during the gap in standard
902 Medicare Part D coverage. To the extent permitted under said act, such
903 payment may be made by the department for a prescription at (A) the
904 lowest price established by the Medicare Part D plan for a preferred
905 drug in the same therapeutic class and category that is dispensed by a
906 preferred pharmacy with the client responsible for any cost differential
907 beyond the department's payment; (B) the lower of the price that
908 would be paid under the ConnPACE program or the negotiated price
909 established by the beneficiary's Medicare Part D plan pursuant to
910 Public Law 108-173, the Medicare Prescription Drug, Improvement,
911 and Modernization Act of 2003, or (C) in consultation with the
912 Secretary of the Office of Policy and Management, at the price that
913 would be paid under the ConnPACE program. Payment shall be made
914 under the ConnPACE program for prescription drugs that are not
915 Medicare Part D drugs, as defined in said act.

916 [(2)] (3) Payment for a replacement prescription under the program
917 shall be made only if the eligible person signs a statement, on such
918 form as the commissioner prescribes and subject to penalty under
919 section 17b-497, that the prescription drug is lost or was stolen or
920 destroyed and the person has made a good faith effort to recover the
921 prescription drug, except that payment for a replacement prescription
922 shall not be made on behalf of a person more than twice in a calendar
923 year. [No copayment shall be required for such replacement
924 prescription.]

925 (c) Any eligible resident who (1) is insured under a policy, including

926 an endorsed Medicare prescription drug discount card, which
927 provides full or partial coverage for prescription drugs, and (2) expects
928 to exhaust such coverage, may apply to participate in the program
929 prior to the exhaustion of such coverage. Such application shall be
930 valid for the applicable income year. To be included in the program, on
931 or after the date the applicant exhausts such coverage, the applicant or
932 the applicant's designee shall notify the department that such coverage
933 is exhausted and, if required by the department, shall submit evidence
934 of exhaustion of coverage. Not later than ten days after an eligible
935 resident submits such evidence, such resident shall be included in the
936 program. The program shall, except for those beneficiaries with an
937 endorsed Medicare prescription drug discount card, (A) cover
938 prescriptions that are not covered by any other plan of insurance or
939 assistance available to the eligible resident and that meet the
940 requirements of this chapter, and (B) retroactively cover such
941 prescriptions filled after or concurrently with the exhaustion of such
942 coverage. Nothing in this subsection shall be construed to prevent a
943 resident from applying to participate in the program as otherwise
944 permitted by this chapter and regulations adopted pursuant to this
945 chapter.

946 (d) (1) As a condition of eligibility for participation in the
947 ConnPACE program, a resident with an income at or below one
948 hundred thirty-five per cent of the federal poverty level, who is
949 Medicare Part A or Part B eligible, shall obtain annually an endorsed
950 Medicare prescription drug discount card designated by the
951 Commissioner of Social Services for use in conjunction with the
952 ConnPACE program. The commissioner shall be the authorized
953 representative of such resident for the purpose of enrolling a resident
954 in the transitional assistance program of Public Law 108-173, the
955 Medicare Prescription Drug, Improvement, and Modernization Act of
956 2003. As the authorized representative for this purpose, the
957 commissioner may sign required forms and enroll such resident in an
958 endorsed Medicare prescription drug discount card on [his or her] the
959 resident's behalf. Such resident shall have the opportunity to select an

960 endorsed Medicare prescription drug discount card designated by the
961 commissioner for use in conjunction with the ConnPACE program,
962 and shall be notified of such opportunity by the commissioner. In the
963 event that such resident does not select an endorsed Medicare
964 prescription drug discount card designated by the commissioner for
965 use in conjunction with the ConnPACE program within a reasonable
966 period of time, as determined by the commissioner, the department
967 shall enroll the resident in an endorsed Medicare prescription drug
968 discount card designated by the commissioner. The provisions of this
969 subdivision shall remain in effect until the effective date of the
970 Medicare Part D program pursuant to Public Law 108-173, the
971 Medicare Prescription Drug, Improvement, and Modernization Act of
972 2003.

973 (2) The commissioner may require, as a condition of eligibility for
974 participation in the ConnPACE program, that a resident with an
975 income above one hundred thirty-five per cent of the federal poverty
976 level, who is Medicare Part A or Part B eligible, obtain an endorsed
977 Medicare prescription drug discount card designated by the
978 commissioner for use in conjunction with the ConnPACE program if
979 obtaining such discount card is determined by the commissioner to be
980 cost-effective to the state. In such an event, the commissioner may
981 provide payment for any Medicare prescription drug discount card
982 enrollment fees. The provisions of this subdivision shall remain in
983 effect until the effective date of the Medicare Part D program pursuant
984 to Public Law 108-173, the Medicare Prescription Drug, Improvement,
985 and Modernization Act of 2003.

986 (e) On and after the effective date of the Medicare Part D program
987 pursuant to Public Law 108-173, the Medicare Prescription Drug,
988 Improvement, and Modernization Act of 2003, enrollment in the
989 Medicare Part D program, for individuals eligible for such program in
990 accordance with said act, shall be a condition of eligibility for the
991 ConnPACE program. The ConnPACE program shall cover the
992 financial costs of Medicare Part D participation for ConnPACE
993 recipients enrolled in Medicare Part D in accordance with subsection

994 (b) of this section. Effective July 1, 2005, a ConnPACE recipient shall, as
995 a condition of eligibility, provide information regarding the recipient's
996 assets and income, as defined by said act, and that of the recipient's
997 spouse, provided said spouse resides in the same household, as
998 required by the Department of Social Services in order to determine
999 the extent of benefits for which the recipient is eligible under Medicare
1000 Part D.

1001 (f) The Commissioner of Social Services shall be the authorized
1002 representative of a ConnPACE applicant or recipient for the purpose of
1003 submitting an application to the Social Security Administration to
1004 obtain the low income subsidy benefit provided under Public Law 108-
1005 173, the Medicare Prescription Drug, Improvement, and
1006 Modernization Act of 2003. As the authorized representative for this
1007 purpose, the commissioner may also sign required forms and enroll
1008 the applicant or recipient in a Medicare Part D plan on the applicant or
1009 recipient's behalf. The applicant or recipient shall have the opportunity
1010 to select a Medicare Part D plan and shall be notified of such
1011 opportunity by the commissioner. In the event that such applicant or
1012 recipient does not select a Medicare Part D plan within a reasonable
1013 period of time, as determined by the commissioner, the department
1014 shall enroll the applicant or recipient in a Medicare Part D plan
1015 designated by the commissioner in accordance with said act. The
1016 applicant or recipient shall appoint the commissioner as such
1017 applicant's or recipient's representative for the purpose of appealing
1018 any denial of Medicare Part D benefits and for any other purpose
1019 allowed under said act and deemed necessary by the commissioner.

1020 [(e)] (g) The Commissioner of Social Services may adopt regulations,
1021 in accordance with the provisions of chapter 54, to implement the
1022 provisions of subsection (c) of this section. Such regulations may
1023 provide for the electronic transmission of relevant coverage
1024 information between a pharmacist and the department or between an
1025 insurer and the department in order to expedite applications and
1026 notice. The commissioner may implement the policies and procedures
1027 necessary to carry out the provisions of this section while in the

1028 process of adopting such policies and procedures in regulation form,
1029 provided notice of intent to adopt the regulations is published not later
1030 than twenty days after the date of implementation. Such policies and
1031 procedures shall be valid until the time the final regulations are
1032 adopted.

1033 Sec. 23. Section 17b-264 of the general statutes is repealed and the
1034 following is substituted in lieu thereof (*Effective July 1, 2005*):

1035 All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive,
1036 17b-79 to 17b-103, inclusive, and 17b-600 to 17b-604, inclusive, are
1037 extended to the medical assistance program except such provisions as
1038 are inconsistent with federal law and regulations governing Title XIX
1039 of the Social Security Amendments of 1965 and sections 17b-260 to 17b-
1040 262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to [17b-362]
1041 17b-361, inclusive.

1042 Sec. 24. Subsection (a) of section 17b-266 of the general statutes is
1043 repealed and the following is substituted in lieu thereof (*Effective July*
1044 *1, 2005*):

1045 (a) The Commissioner of Social Services may, when [he] the
1046 commissioner finds it to be in the public interest, fund part or all of the
1047 cost of benefits to any recipient under sections 17b-260 to 17b-262,
1048 inclusive, 17b-264 to 17b-285, inclusive, 17b-357 to [17b-362] 17b-361,
1049 inclusive, 17b-289 to 17b-303, inclusive, and section 16 of public act 97-
1050 1 of the October 29 special session*, through the purchase of insurance
1051 from any organization authorized to do a health insurance business in
1052 this state or from any organization specified in subsection (b) of this
1053 section.

1054 Sec. 25. Subsection (a) of section 17b-267 of the general statutes is
1055 repealed and the following is substituted in lieu thereof (*Effective July*
1056 *1, 2005*):

1057 (a) If any group or association of providers of medical assistance
1058 services wishes to have payments as provided for under sections 17b-

1059 260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to
1060 [17b-362] 17b-361, inclusive, to such providers made through a
1061 national, state or other public or private agency or organization and
1062 nominates such agency or organization for this purpose, the
1063 Commissioner of Social Services is authorized to enter into an
1064 agreement with such agency or organization providing for the
1065 determination by such agency or organization, subject to such review
1066 by the Commissioner of Social Services as may be provided for by the
1067 agreement, of the payments required to be made to such providers at
1068 the rates set by the hospital cost commission, and for the making of
1069 such payments by such agency or organization to such providers. Such
1070 agreement may also include provision for the agency or organization
1071 to do all or any part of the following: With respect to the providers of
1072 services which are to receive payments through it, (1) to serve as a
1073 center for, and to communicate to providers, any information or
1074 instructions furnished to it by the Commissioner of Social Services, and
1075 to serve as a channel of communication from providers to the
1076 Commissioner of Social Services; (2) to make such audits of the records
1077 of providers as may be necessary to insure that proper payments are
1078 made under this section; and (3) to perform such other functions as are
1079 necessary to carry out the provisions of sections 17b-267 to 17b-271,
1080 inclusive.

1081 Sec. 26. Section 17b-272 of the general statutes is repealed and the
1082 following is substituted in lieu thereof (*Effective July 1, 2005*):

1083 Effective July 1, 1998, the Commissioner of Social Services shall
1084 permit patients residing in nursing homes, chronic disease hospitals
1085 and state humane institutions who are medical assistance recipients
1086 under sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285,
1087 inclusive, and 17b-357 to [17b-362] 17b-361, inclusive, to have a
1088 monthly personal fund allowance of fifty dollars. Effective July 1, 1999,
1089 the commissioner shall increase such allowance annually to reflect the
1090 annual inflation adjustment in Social Security income, if any.

1091 Sec. 27. Section 53a-290 of the general statutes is repealed and the

1092 following is substituted in lieu thereof (*Effective July 1, 2005*):

1093 A person commits vendor fraud when, with intent to defraud and
1094 acting on such person's own behalf or on behalf of an entity, such
1095 person provides goods or services to a beneficiary under sections 17b-
1096 22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-103, inclusive, 17b-180a,
1097 17b-183, 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive,
1098 17b-357 to [17b-362] 17b-361, inclusive, 17b-600 to 17b-604, inclusive,
1099 17b-749, 17b-807 and 17b-808 or provides services to a recipient under
1100 Title XIX of the Social Security Act, as amended, and, (1) presents for
1101 payment any false claim for goods or services performed; (2) accepts
1102 payment for goods or services performed, which exceeds either the
1103 amounts due for goods or services performed, or the amounts
1104 authorized by law for the cost of such goods or services; (3) solicits to
1105 perform services for or sell goods to any such beneficiary, knowing
1106 that such beneficiary is not in need of such goods or services; (4) sells
1107 goods to or performs services for any such beneficiary without prior
1108 authorization by the Department of Social Services, when prior
1109 authorization is required by said department for the buying of such
1110 goods or the performance of any service; or (5) accepts from any
1111 person or source other than the state an additional compensation in
1112 excess of the amount authorized by law.

1113 Sec. 28. (NEW) (*Effective July 1, 2005*) The Commissioner of Mental
1114 Retardation, or the commissioner's designee, may be the authorized
1115 representative of an applicant or recipient of services provided by the
1116 Department of Mental Retardation for the purpose of submitting an
1117 application to the Social Security Administration to obtain the low
1118 income subsidy benefit provided under Public Law 108-173, the
1119 Medicare Prescription Drug, Improvement, and Modernization Act of
1120 2003. As the authorized representative for this purpose, the
1121 commissioner, or the commissioner's designee, may also sign required
1122 forms and enroll the applicant or recipient in a Medicare Part D plan
1123 on the applicant's or recipient's behalf. The applicant or recipient shall
1124 have the opportunity to select a Medicare Part D plan and shall be
1125 notified of such opportunity by the commissioner. In the event that

1126 such applicant or recipient does not select a Medicare Part D plan
1127 within a reasonable period of time, as determined by the
1128 commissioner, the department shall enroll the applicant or recipient in
1129 a Medicare Part D plan designated by the commissioner in accordance
1130 with said act. The applicant or recipient shall appoint the
1131 commissioner, or the commissioner's designee, as such applicant's or
1132 recipient's authorized representative for the purpose of appealing any
1133 denial of Medicare Part D benefits and for any other purpose allowed
1134 under said act and deemed necessary by the commissioner.

1135 Sec. 29. (NEW) (*Effective July 1, 2005*) The Commissioner of Mental
1136 Heath and Addiction Services, or the commissioner's designee, may be
1137 the authorized representative of an applicant or recipient of services
1138 provided by the Department of Mental Health and Addiction Services
1139 for the purpose of submitting an application to the Social Security
1140 Administration to obtain the low income subsidy benefit provided
1141 under Public Law 108-173, the Medicare Prescription Drug,
1142 Improvement, and Modernization Act of 2003. As the authorized
1143 representative for this purpose, the commissioner, or the
1144 commissioner's designee, may also sign required forms and enroll the
1145 applicant or recipient in a Medicare Part D plan on the applicant's or
1146 recipient's behalf. The applicant or recipient shall have the opportunity
1147 to select a Medicare Part D plan and shall be notified of such
1148 opportunity by the commissioner. In the event that such applicant or
1149 recipient does not select a Medicare Part D plan within a reasonable
1150 period of time, as determined by the commissioner, the department
1151 shall enroll the applicant or recipient in a Medicare Part D plan
1152 designated by the commissioner in accordance with said act. The
1153 applicant or recipient shall appoint the commissioner, or the
1154 commissioner's designee, as such applicant's or recipient's authorized
1155 representative for the purpose of appealing any denial of Medicare
1156 Part D benefits and for any other purpose allowed under said act and
1157 deemed necessary by the commissioner.

1158 Sec. 30. (*Effective July 1, 2005*) Not later than January 1, 2007, the
1159 Commissioner of Social Services shall submit an interim status report,

1160 in accordance with section 11-4a of the general statutes, relative to the
1161 implementation of the Medicare Part D program established pursuant
1162 to Public Law 108-173, the Medicare Prescription Drug, Improvement,
1163 and Modernization Act of 2003 to the joint standing committees of the
1164 General Assembly having cognizance of matters relating to public
1165 health, human services and appropriations and the budgets of state
1166 agencies.

1167 Sec. 31. Section 17a-218 of the general statutes is amended by adding
1168 subsection (g) as follows (*Effective July 1, 2005*):

1169 (NEW) (g) Any person who is in or is seeking a placement through
1170 the Department of Mental Retardation or is receiving any support or
1171 service that is included within or covered by any federal program
1172 being administered and operated by the Department of Social Services
1173 and the Department of Mental Retardation, and who meets the
1174 eligibility criteria for the federal program, shall enroll in such program
1175 in order to continue in the existing placement or to remain eligible for
1176 a placement or continue to receive such support or service. Any person
1177 who is ineligible for such federal program due to excess income or
1178 assets may continue in existing placement, or continue to receive
1179 existing supports and services through the Department of Mental
1180 Retardation while spending down available excess income and assets
1181 until such person qualifies for enrollment in the applicable federal
1182 program. The Commissioner of Mental Retardation may make
1183 exceptions to the requirements of this provision and provide or
1184 continue to provide, within available appropriations, placement,
1185 support or services to individuals who are not eligible for enrollment
1186 in such federal programs and for whom it is determined there is a legal
1187 requirement to serve pursuant to state or federal law or court order.

1188 Sec. 32. Section 17a-485c of the general statutes is repealed and the
1189 following is substituted in lieu thereof (*Effective July 1, 2005*):

1190 (a) The Commissioner of Mental Health and Addiction Services, in
1191 collaboration with the Commissioners of Social Services, Children and

1192 Families and Economic and Community Development and the
1193 Connecticut Housing Finance Authority, shall establish a Supportive
1194 Housing [Pilots] Initiative to provide additional units of affordable
1195 housing and support services to eligible persons. The Supportive
1196 Housing Initiative shall be implemented in two phases with the first
1197 phase to be known as the Supportive Housing Pilots Initiative and the
1198 second phase to be known as the Next Steps Initiative.

1199 (b) The Supportive Housing Pilots Initiative shall provide up to six
1200 hundred fifty additional units of affordable housing and support
1201 services to eligible households, as defined in section 17a-484a, and to
1202 persons with serious mental health needs who are community-
1203 supervised offenders supervised by the executive or judicial branch.
1204 Such housing shall be permanent supportive housing or transitional
1205 living programs, and the permanent supportive housing may include
1206 both individuals and families with special needs and individuals and
1207 families without such needs.

1208 ~~[(b)]~~ (c) [The Supportive Housing Pilots Initiative shall provide up
1209 to six hundred fifty dwelling units.] Not later than January 1, 2002, the
1210 Secretary of the Office of Policy and Management and the
1211 Commissioner of Mental Health and Addiction Services shall enter
1212 into a memorandum of understanding with the Departments of Social
1213 Services and Economic and Community Development and the
1214 Connecticut Housing Finance Authority. The memorandum of
1215 understanding shall provide that: (1) A collaborative plan shall be
1216 submitted with specific timetables to create up to six hundred fifty
1217 dwelling units of supportive housing, which may include the
1218 construction of up to three hundred new units of supportive housing;
1219 (2) the Department of Social Services may provide project-based rental
1220 subsidy certificates; (3) the Connecticut Housing Finance Authority
1221 and the Department of Economic and Community Development shall
1222 provide grants, mortgage loans and tax credits that offer a viable
1223 financing package, including capitalized operating reserves, for the
1224 construction of up to three hundred new units of supportive housing;
1225 (4) the Department of Mental Health and Addiction Services shall

1226 provide annual grants to the projects for supportive services during
1227 the term of any mortgage loan; (5) there shall be a plan for private and
1228 federal predevelopment financing and financing from nonstate sources
1229 for grants and loans from private investment through federal and state
1230 tax credit programs and federal project-based rental subsidies; and (6)
1231 not later than July 1, 2002, the Connecticut Housing Finance Authority
1232 shall issue a request for proposals by persons or entities interested in
1233 participating in such initiative with priority given to applicants that
1234 include organizations deemed qualified to provide services by the
1235 Department of Mental Health and Addiction Services pursuant to a
1236 request for qualifications. The Connecticut Housing Finance Authority
1237 shall review and underwrite projects developed under the Supportive
1238 Housing Pilots Initiative.

1239 (d) The Next Steps Initiative shall provide up to five hundred
1240 additional units of affordable housing and support services to: (1)
1241 Eligible households, as defined in section 17a-484a; (2) families who
1242 are eligible under the state plan for the federal temporary assistance
1243 for needy families program; (3) adults who are eighteen to twenty-
1244 three years of age, inclusive, and who are homeless, or at risk for
1245 becoming homeless because they are transitioning from foster care or
1246 other residential programs; and (4) persons with serious mental health
1247 needs who are community-supervised offenders supervised by the
1248 executive or judicial branch. Such housing shall be permanent
1249 supportive housing and may include both individuals and families
1250 with special needs and individuals and families without such needs.

1251 (e) Not later than October 1, 2005, the Secretary of the Office of
1252 Policy and Management and the Commissioner of Mental Health and
1253 Addiction Services shall enter into a memorandum of understanding
1254 with the Departments of Social Services, Children and Families and
1255 Economic and Community Development and the Connecticut Housing
1256 Finance Authority. The memorandum of understanding shall provide
1257 that: (1) A collaborative plan shall be submitted with specific
1258 timetables to create up to five hundred dwelling units of supportive
1259 housing under the Next Steps Initiative; (2) the Department of Social

1260 Services may provide subsidies, including, but not limited to, project-
1261 based rental subsidy certificates during the term of any mortgage loan;
1262 (3) the Connecticut Housing Finance Authority and the Department of
1263 Economic and Community Development shall provide grants,
1264 mortgage loans or tax credits that offer a viable financing package,
1265 including capitalized operating reserves; (4) after January 1, 2006, the
1266 State Treasurer and the Secretary of the Office of Policy and
1267 Management may enter into a debt service agreement to provide
1268 funding for debt service costs for Section 501 (c)(3) of the Internal
1269 Revenue Code bonds issued by the Connecticut Housing Finance
1270 Authority; (5) the Departments of Mental Health and Addiction
1271 Services, Social Services and Children and Families shall provide
1272 annual grants to the projects for supportive services during the term of
1273 any mortgage loan; and (6) there shall be a plan for private and federal
1274 predevelopment financing and financing from nonstate sources for
1275 grants and loans from private investment through federal and state tax
1276 credit programs and federal project-based rental subsidies. Not later
1277 than January 1, 2006, the Connecticut Housing Finance Authority shall
1278 issue one or more requests for proposals by persons or entities
1279 interested in participating in such initiative. The Connecticut Housing
1280 Finance Authority shall review and underwrite projects developed
1281 under the Supportive Housing Initiative.

1282 [(c)] (f) Not later than January 1, [2004] 2006, the Commissioners of
1283 Mental Health and Addiction Services, Children and Families, Social
1284 Services and Economic and Community Development and the
1285 Connecticut Housing Finance Authority shall submit an interim status
1286 report relative to the Supportive Housing [Pilots] Initiative established
1287 under this section to the joint standing committees of the General
1288 Assembly having cognizance of matters relating to public health,
1289 human services, finance, revenue and bonding and appropriations and
1290 the budgets of state agencies. Not later than January 1, [2006] 2007, the
1291 Commissioners of Mental Health and Addiction Services and
1292 Economic and Community Development and the Connecticut Housing
1293 Finance Authority shall submit a final report to said committees with

1294 respect to the Supportive Housing [Pilots] Initiative and the report
1295 shall include, but not be limited to, information indicating (1) the
1296 number and location of the units of supportive housing created, (2) the
1297 number of individuals served, (3) the number and type of services
1298 offered, and (4) the estimated amount of cost avoidance achieved as a
1299 direct result of such initiative.

1300 Sec. 33. (NEW) (*Effective July 1, 2005*) (a) For purposes of this section
1301 "state assistance" means a payment by the state of actual debt service,
1302 comprised on principal, interest and reasonable operating reserves.

1303 (b) The state, acting by and through the Secretary of the Office of
1304 Policy and Management and State Treasurer, may enter into a contract
1305 or contracts with the Connecticut Housing Finance Authority that
1306 provide the state shall pay actual debt service, comprised on principal,
1307 interest and reasonable operating repair and replacement reserves to
1308 the authority on mortgage loans made by the authority pursuant to the
1309 provisions of section 17a-485c of the general statutes, as amended by
1310 this act. Any such contract entered into pursuant to this section shall
1311 include provisions that the Secretary of the Office of Policy and
1312 Management and the State Treasurer find: (1) Necessary to assure the
1313 effectuation of the Supportive Housing Initiative, (2) appropriate for
1314 repayment of the state assistance to the state as a result of payment of
1315 mortgage loans made by the authority from federal or other sources of
1316 revenues, if any, and (3) in the best interests of the state to allow that
1317 such state assistance be paid by the state directly to the trustee or
1318 paying agent for any bonds or refunding bonds, as applicable, with
1319 respect to which the state assistance is provided. Any provision of
1320 such a contract entered into providing for payments equal to annual
1321 debt service shall be deemed a contract of the state with the holders of
1322 any bonds or refunding bonds, as applicable, and appropriation of all
1323 amounts necessary to meet punctually the terms of such provision is
1324 hereby made and the State Treasurer shall pay such amount as the
1325 same become due. The Connecticut Housing Finance Authority may
1326 pledge such state assistance as security for the payment of such bonds
1327 or refunding bonds issued by said authority. Any bonds so issued for

1328 the Supportive Housing Initiative by the Connecticut Housing Finance
1329 Authority and at any time outstanding may at any time or from time to
1330 time be refunded, in whole or in part, by the Connecticut Housing
1331 Finance Authority by the issuance of its refunding bonds in such
1332 amounts as the authority may deem necessary or appropriate but not
1333 exceeding an amount sufficient to refund the principal amount of the
1334 bonds to be so refunded, any unpaid interest thereon, and any
1335 premiums, commissions and costs of issuance necessary to be paid in
1336 connection therewith. Any such refunding may be effected whether
1337 the bonds to be refunded shall have matured or shall thereafter
1338 mature.

1339 Sec. 34. Section 17b-812 of the general statutes is repealed and the
1340 following is substituted in lieu thereof (*Effective July 1, 2005*):

1341 (a) The Commissioner of Social Services shall implement and
1342 administer a program of rental assistance for low-income families
1343 living in privately-owned rental housing. For the purposes of this
1344 section, a low-income family is one whose income does not exceed fifty
1345 per cent of the median family income for the area of the state in which
1346 such family lives, as determined by the commissioner.

1347 (b) Housing eligible for participation in the program shall comply
1348 with applicable state and local health, housing, building and safety
1349 codes.

1350 (c) In addition to an element in which rental assistance certificates
1351 are made available to qualified tenants, to be used in eligible housing
1352 which such tenants are able to locate, the program may include a
1353 housing support element in which rental assistance for tenants is
1354 linked to participation by the property owner in other municipal, state
1355 or federal housing repair, rehabilitation or financing programs. The
1356 commissioner shall use rental assistance under this section so as to
1357 encourage the preservation of existing housing and the revitalization
1358 of neighborhoods or the creation of additional rental housing.

1359 (d) The commissioner may designate a portion of the rental

1360 assistance certificates available under the program for tenant-based
1361 and project-based supportive housing units. To the extent practicable
1362 rental assistance certificates issued for supportive housing shall adhere
1363 to the requirements of the federal Housing Choice Voucher program,
1364 42 USC 1437f(o), relative to calculating the tenant's share of the rent to
1365 be paid.

1366 [(d)] (e) The commissioner shall administer the program under this
1367 section to promote housing choice for certificate holders and
1368 encourage racial and economic integration. The commissioner shall
1369 establish maximum rent levels for each municipality in a manner that
1370 promotes the use of the program in all municipalities. Any certificate
1371 issued pursuant to this section may be used for housing in any
1372 municipality in the state. The commissioner shall inform certificate
1373 holders that a certificate may be used in any municipality and, to the
1374 extent practicable, the commissioner shall assist certificate holders in
1375 finding housing in the municipality of their choice.

1376 [(e)] (f) Nothing in this section shall give any person a right to
1377 continued receipt of rental assistance at any time that the program is
1378 not funded.

1379 [(f)] (g) The commissioner shall adopt regulations in accordance
1380 with the provisions of chapter 54 to carry out the purposes of this
1381 section. The regulations shall establish maximum income eligibility
1382 guidelines for such rental assistance and criteria for determining the
1383 amount of rental assistance which shall be provided to eligible
1384 families.

1385 Sec. 35. (*Effective from passage*) The Department of Mental
1386 Retardation shall, within available appropriations, contract for a unit
1387 cost study for the Birth-To-Three Early Intervention Program under
1388 sections 17a-248 to 17a-248g, inclusive, of the general statutes. The
1389 study shall examine operational costs for both contracted services and
1390 for services provided by state employees and shall include a
1391 computation of such costs as salary, benefits, contracted services,

1392 administrative support, rent, vehicles, equipment, travel, materials and
1393 supplies, utilities, insurance and training. The contract shall provide
1394 for input by private provider representatives who are current
1395 providers in the program. The study shall be completed by February 1,
1396 2006, and the Commissioner of Mental Retardation shall report, in
1397 accordance with section 11-4a of the general statutes, to the Governor
1398 and the joint standing committees of the General Assembly having
1399 cognizance of matters relating to public health and appropriations and
1400 the budgets of state agencies on the results of the study by January 1,
1401 2006.

1402 Sec. 36. (*Effective July 1, 2005*) The joint standing committee of the
1403 General Assembly having cognizance of matters relating to insurance
1404 and real estate shall conduct a study on the potential implementation
1405 of a public-private partnership to be called the Nutmeg Health
1406 Partnership Insurance Plan. The committee shall investigate ideas to
1407 accomplish the following goals: Increase the number of residents of
1408 this state who have health insurance, provide broader access to health
1409 care and make health care more affordable to residents of this state.
1410 The committee shall develop a plan to achieve these goals and shall
1411 issue a report to the General Assembly in accordance with the
1412 provisions of section 11-4a of the general statutes no later than
1413 February 1, 2006, that contains the specifics of such plan and that
1414 contemplates legislation to implement the plan as soon as is
1415 practicable.

1416 Sec. 37. (*Effective from passage*) Notwithstanding the provisions of
1417 section 3-125a of the general statutes, the provisions of the settlement
1418 agreement in the action Emily J. et al. v. M. Jodi Rell, et al., United
1419 States District Court, District of Connecticut, Civil Action No.
1420 3:93CV1944 (RNC), requiring expenditure from the General Fund
1421 budget in excess of two million five hundred thousand dollars and
1422 submitted by the Attorney General to this Assembly for approval on
1423 June 7, 2005, are approved.

1424 Sec. 38. Subsection (a) of section 17b-106 of the general statutes is

1425 repealed and the following is substituted in lieu thereof (*Effective July*
1426 *1, 2005*):

1427 (a) On July 1, 1985, the Commissioner of Social Services shall
1428 increase the adult payment standards for the state supplement to the
1429 federal Supplemental Security Income Program by four and
1430 three-tenths per cent over the standards for the fiscal year ending June
1431 30, 1985, provided the commissioner shall apply the appropriate
1432 disregards. Notwithstanding the provisions of any regulation to the
1433 contrary, effective July 1, 1994, the commissioner shall reduce the
1434 appropriate unearned income disregard for recipients of the state
1435 supplement to the federal Supplemental Security Income Program by
1436 seven per cent, provided if sufficient funds are available within
1437 accounts in the Department of Social Services and are transferred to
1438 the old age assistance account, the aid to the blind account and the aid
1439 to the disabled account, the commissioner shall increase the unearned
1440 income disregard for recipients of the state supplement to the federal
1441 Supplemental Security Income Program to a level not to exceed that in
1442 effect on June 30, 1994. On July 1, 1989, and annually thereafter, the
1443 Commissioner of Social Services shall increase the adult payment
1444 standards over those of the previous fiscal year for the state
1445 supplement to the federal Supplemental Security Income Program by
1446 the percentage increase, if any, in the most recent calendar year
1447 average in the consumer price index for urban consumers over the
1448 average for the previous calendar year, provided the annual increase,
1449 if any, shall not exceed five per cent, except that the adult payment
1450 standards for the fiscal years ending June 30, 1993, June 30, 1994, June
1451 30, 1995, June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June
1452 30, 2000, June 30, 2001, June 30, 2002, June 30, 2003, June 30, 2004, and
1453 June 30, 2005, June 30, 2006 and June 30, 2007, shall not be increased.
1454 Effective October 1, 1991, the coverage of excess utility costs for
1455 recipients of the state supplement to the federal Supplemental Security
1456 Income Program is eliminated. Notwithstanding the provisions of this
1457 section, the Commissioner of Social Services may increase the personal
1458 needs allowance component of the adult payment standard as

1459 necessary to meet federal maintenance of effort requirements.

1460 Sec. 39. Subsection (a) of section 17b-802 of the general statutes is
1461 repealed and the following is substituted in lieu thereof (*Effective July*
1462 *1, 2005*):

1463 (a) The Commissioner of Social Services shall establish, within
1464 available appropriations, and administer a security deposit guarantee
1465 program for persons who (1) (A) are recipients of temporary family
1466 assistance, aid under the state supplement program, or state-
1467 administered general assistance, or (B) have a documented showing of
1468 financial need, and (2) (A) are residing in emergency shelters or other
1469 emergency housing, cannot remain in permanent housing due to any
1470 reason specified in subsection (a) of section 17b-808, or are served a
1471 notice to quit in a summary process action instituted pursuant to
1472 chapter 832, or (B) have a rental assistance program or federal Section 8
1473 certificate or voucher. Under such program, the Commissioner of
1474 Social Services may provide security deposit guarantees for use by
1475 such persons in lieu of a security deposit on a rental dwelling unit.
1476 Eligible persons may receive a security deposit guarantee in an amount
1477 not to exceed the equivalent of two months' rent on such rental unit.
1478 No person may apply for and receive a security deposit guarantee
1479 more than once in any eighteen-month period without the express
1480 authorization of the Commissioner of Social Services, except as
1481 provided in subsection (b) of this section. The Commissioner of Social
1482 Services may deny eligibility for the security deposit guarantee
1483 program to an applicant who has made more than two claims in a five-
1484 year period. The Commissioner of Social Services may establish
1485 priorities for [allocating] providing security deposit guarantees
1486 [between] to eligible persons described in subparagraphs (A) and (B)
1487 of subdivision (2) of this subsection in order to administer the program
1488 within available appropriations.

1489 Sec. 40. Section 17b-261a of the general statutes, as amended by
1490 house bill 6688 of the current session, is repealed and the following is
1491 substituted in lieu thereof (*Effective from passage*):

1492 (a) Any transfer or assignment of assets resulting in the imposition
1493 of a penalty period shall be presumed to be made with the intent, on
1494 the part of the transferor or the transferee, to enable the transferor to
1495 obtain or maintain eligibility for medical assistance. This presumption
1496 may be rebutted only by clear and convincing evidence that the
1497 transferor's eligibility or potential eligibility for medical assistance was
1498 not a basis for the transfer or assignment.

1499 (b) Any transfer or assignment of assets resulting in the
1500 establishment or imposition of a penalty period shall create a debt, as
1501 defined in section 36a-645, that shall be due and owing by the
1502 transferor or transferee to the Department of Social Services in an
1503 amount equal to the amount of the medical assistance provided to or
1504 on behalf of the transferor on or after the date of the transfer of assets,
1505 but said amount shall not exceed the fair market value of the assets at
1506 the time of transfer. The Commissioner of Social Services, the
1507 Commissioner of Administrative Services and the Attorney General
1508 shall have the power or authority to seek administrative, legal or
1509 equitable relief as provided by other statutes or by common law.

1510 (c) The Commissioner of Social Services may waive the imposition
1511 of a penalty period when the transferor (1) in accordance with the
1512 provisions of section 3025.25 of the department's Uniform Policy
1513 Manual, suffers from dementia at the time of application for medical
1514 assistance and cannot explain transfers that would otherwise result in
1515 the imposition of a penalty period; or (2) suffered from dementia at the
1516 time of the transfer; or (3) was exploited into making such a transfer
1517 due to dementia. Waiver of the imposition of a penalty period does not
1518 prohibit the establishment of a debt in accordance with subsection (b)
1519 of this section.

1520 [(c)] (d) The Commissioner of Social Services, pursuant to section
1521 17b-10, shall implement the policies and procedures necessary to carry
1522 out the provisions of this section while in the process of adopting such
1523 policies and procedures in regulation form, provided notice of intent to
1524 adopt regulations is published in the Connecticut Law Journal not later

1525 than twenty days after implementation. Such policies and procedures
1526 shall be valid until the time final regulations are effective.

1527 Sec. 41. Subsection (a) of section 17b-354 of the general statutes is
1528 repealed and the following is substituted in lieu thereof (*Effective July*
1529 *1, 2005*):

1530 (a) Except for applications deemed complete as of August 9, 1991,
1531 the Department of Social Services shall not accept or approve any
1532 requests for additional nursing home beds or modify the capital cost of
1533 any prior approval for the period from September 4, 1991, through
1534 June 30, 2007, except (1) beds restricted to use by patients with
1535 acquired immune deficiency syndrome or traumatic brain injury; (2)
1536 beds associated with a continuing care facility which guarantees life
1537 care for its residents; (3) Medicaid certified beds to be relocated from
1538 one licensed nursing facility to another licensed nursing facility,
1539 provided (A) the availability of beds in an area of need will not be
1540 adversely affected; (B) no such relocation shall result in an increase in
1541 state expenditures; and (C) the relocation results in a reduction in the
1542 number of nursing facility beds in the state; [and] (4) a request for no
1543 more than twenty beds submitted by a licensed nursing facility that
1544 participates in neither the Medicaid program nor the Medicare
1545 program, admits residents and provides health care to said residents
1546 without regard to their income or assets and demonstrates its financial
1547 ability to provide lifetime nursing home services to such residents
1548 without participating in the Medicaid program to the satisfaction of
1549 the department, provided the department does not accept or approve
1550 more than one request pursuant to this subdivision; and (5) a request
1551 for not nor more than twenty beds associated with a free standing
1552 facility dedicated to providing hospice care services for terminally ill
1553 persons operated by an organization previously authorized by the
1554 Department of Public Health to provide hospice services in accordance
1555 with section 19a-122b. Notwithstanding the provisions of this
1556 subsection, any provision of the general statutes or any decision of the
1557 Office of Health Care Access, (i) the date by which construction shall
1558 begin for each nursing home certificate of need in effect August 1,

1559 1991, shall be December 31, 1992, (ii) the date by which a nursing home
1560 shall be licensed under each such certificate of need shall be October 1,
1561 1995, and (iii) the imposition of such dates shall not require action by
1562 the Commissioner of Social Services. Except as provided in subsection
1563 (c) of this section, a nursing home certificate of need in effect August 1,
1564 1991, shall expire if construction has not begun or licensure has not
1565 been obtained in compliance with the dates set forth in subparagraphs
1566 (i) and (ii) of this subsection.

1567 Sec. 42. (*Effective from passage*) Not later than January 1, 2006, the
1568 Commissioner of Social Services shall report to the joint standing
1569 committees of the General Assembly having cognizance of matters
1570 relating to public health, human services and appropriations and the
1571 budgets of state agencies on the feasibility and costs of establishing a
1572 program to purchase and continue health insurance policies for
1573 persons with human immunodeficiency virus or acquired
1574 immunodeficiency virus that would operate under the same eligibility
1575 criteria utilized to make eligibility determinations for the Connecticut
1576 AIDS drug assistance program.

1577 Sec. 43. Section 17a-93 of the general statutes is repealed and the
1578 following is substituted in lieu thereof (*Effective from passage*):

1579 As used in sections 17a-90 to 17a-124, inclusive, and 17a-152:

1580 (a) "Child" means any person under eighteen years of age, except as
1581 otherwise specified, or any person under twenty-one years of age who
1582 is in full-time attendance in a secondary school, a technical school, a
1583 college or a state-accredited job training program;

1584 (b) "Parent" means natural or adoptive parent;

1585 (c) "Adoption" means the establishment by court order of the legal
1586 relationship of parent and child;

1587 (d) "Guardianship" means guardianship, unless otherwise specified,
1588 of the person of a minor and refers to the obligation of care and

1589 control, the right to custody and the duty and authority to make major
1590 decisions affecting such minor's welfare, including, but not limited to,
1591 consent determinations regarding marriage, enlistment in the armed
1592 forces and major medical, psychiatric or surgical treatment;

1593 (e) "Termination of parental rights" means the complete severance
1594 by court order of the legal relationship, with all its rights and
1595 responsibilities, between the child and his parent or parents so that the
1596 child is free for adoption except it shall not affect the right of
1597 inheritance of such child or the religious affiliation of such child;

1598 (f) "Statutory parent" means the Commissioner of Children and
1599 Families or that child-placing agency appointed by the court for the
1600 purpose of giving a minor child or minor children in adoption;

1601 (g) "Child-placing agency" means any agency within or without the
1602 state of Connecticut licensed or approved by the Commissioner of
1603 Children and Families in accordance with sections 17a-149 and 17a-
1604 151, and in accordance with such standards which shall be established
1605 by regulations of the Department of Children and Families;

1606 (h) "Child care facility" means a congregate residential setting
1607 licensed by the Department of Children and Families for the out-of-
1608 home placement of children or youth under eighteen years of age,
1609 [licensed by the Department of Children and Families] or any person
1610 under twenty-one years of age who is in full-time attendance in a
1611 secondary school, a technical school, a college or state accredited job
1612 training program and was placed in a congregate residential setting
1613 prior to such person's eighteenth birthday;

1614 (i) "Protective supervision" means a status created by court order
1615 following adjudication of neglect whereby a child's place of abode is
1616 not changed but assistance directed at correcting the neglect is
1617 provided at the request of the court through the Department of
1618 Children and Families or such other social agency as the court may
1619 specify;

1620 (j) "Receiving home" means a facility operated by the Department of
1621 Children and Families to receive and temporarily care for children in
1622 the guardianship or care of the commissioner;

1623 (k) "Protective services" means public welfare services provided
1624 after complaints of abuse, neglect or abandonment, but in the absence
1625 of an adjudication or assumption of jurisdiction by a court;

1626 (l) "Person responsible for the health, welfare or care of a child or
1627 youth" means a child's or a youth's parent, guardian or foster parent;
1628 an employee of a public or private residential home, agency or
1629 institution or other person legally responsible in a residential setting;
1630 or any staff person providing out-of-home care, including center-based
1631 child day care, family day care or group day care, as defined in section
1632 19a-77;

1633 (m) "Foster family" means a person or persons, licensed or certified
1634 by the Department of Children and Families or approved by a licensed
1635 child-placing agency, for the care of a child or children in a private
1636 home;

1637 (n) "Prospective adoptive family" means a person or persons,
1638 licensed by the Department of Children and Families or approved by a
1639 licensed child-placing agency, who is awaiting the placement of, or
1640 who has a child or children placed in their home for the purposes of
1641 adoption;

1642 (o) "Person entrusted with the care of a child or youth" means a
1643 person given access to a child or youth by a person responsible for the
1644 health, welfare or care of a child or youth for the purpose of providing
1645 education, child care, counseling, spiritual guidance, coaching,
1646 training, instruction, tutoring or mentoring of such child or youth.

1647 Sec. 44. Subsection (c) of section 17b-93 of the general statutes is
1648 repealed and the following is substituted in lieu thereof (*Effective*
1649 *October 1, 2005*):

1650 (c) No claim shall be made, or lien applied, against any payment
1651 made pursuant to chapter 135, any payment made pursuant to section
1652 47-88d or 47-287, any moneys received as a settlement or award in a
1653 housing or employment discrimination case, any court-ordered
1654 retroactive rent abatement, including any made pursuant to subsection
1655 (e) of section 47a-14h, section 47a-4a, 47a-5, or 47a-57, or any security
1656 deposit refund pursuant to subsection (d) of section 47a-21 paid to a
1657 beneficiary of assistance under the state supplement program, medical
1658 assistance program, aid to families with dependent children program,
1659 temporary family assistance program or state-administered general
1660 assistance program.

1661 Sec. 45. (NEW) (*Effective October 1, 2005*) Any payment received by a
1662 complainant under chapter 814c of the general statutes or under any
1663 equivalent federal antidiscrimination law, either as a settlement of a
1664 claim or as an award made in a judicial or administrative proceeding,
1665 shall not be considered as income, resources or assets for the purpose
1666 of determining the eligibility of or amount of assistance to be received
1667 by such person in the month of receipt or the three months following
1668 receipt under the state supplement program, Medicaid or any other
1669 medical assistance program, temporary family assistance program,
1670 state-administered general assistance program, or the temporary
1671 assistance for needy families program. After such time period, any
1672 remaining funds shall be subject to state and federal laws governing
1673 such programs, including, but not limited to, provisions concerning
1674 individual development accounts, as defined in section 31-51ww.

1675 Sec. 46. (NEW) (*Effective July 1, 2005*) The Commissioner of Social
1676 Services shall establish prior authorization procedures under the
1677 Medicaid program for home health services, such that prior
1678 authorization shall be required for skilled nursing visits that exceed
1679 two per week. Unless there are revisions to the prior authorization
1680 received during the month, providers shall not be required to submit
1681 prior authorization requests more than once a month. The
1682 Commissioner of Social Services may contract with an entity for
1683 administration of any such aspect of prior authorization or may

1684 expand the scope of an existing contract with an entity that performs
1685 utilization review services on behalf of the department. The
1686 commissioner, pursuant to section 17b-10 of the general statutes, may
1687 implement policies and procedures necessary to administer the
1688 provisions of this section while in the process of adopting such policies
1689 and procedures as regulation, provided the commissioner prints notice
1690 of intent to adopt regulations in the Connecticut Law Journal not later
1691 than twenty days after the date of implementation. Policies and
1692 procedures implemented pursuant to this section shall be valid until
1693 the time final regulations are adopted.

1694 Sec. 47. Section 78 of substitute house bill 6940 of the current session
1695 is repealed and the following is substituted in lieu thereof (*Effective July*
1696 *1, 2005*):

1697 (a) For purposes of this section and section 79 of [this act] substitute
1698 house bill 6940 of the current session:

1699 (1) "Commissioner" means the Commissioner of Revenue Services;

1700 (2) "Department" means the Department of Revenue Services;

1701 (3) "Nursing home" means any licensed chronic and convalescent
1702 nursing home or a rest home with nursing supervision, but does not
1703 include, upon approval of the waiver of federal requirements for
1704 uniform and broad-based user fees in accordance with 42 CFR 433.68,
1705 pursuant to section 82 of [this act] substitute house bill 6940 of the
1706 current session, any nursing home that is owned and operated as of
1707 May 1, 2005, by the legal entity that is registered as a continuing care
1708 facility with the Department of Social Services in accordance with
1709 Section 17b-521 of the general statutes, regardless of whether such
1710 nursing home participates in the Medicaid program and any nursing
1711 home licensed after May 1, 2005, that is owned and operated by the
1712 legal entity that is registered as a continuing care facility with the
1713 Department of Social Services in accordance with Section 17b-521 of
1714 the general statutes;

1715 (4) "Medicare day" means a day of nursing home care service
1716 provided to an individual who is eligible for payment, in full or with a
1717 coinsurance requirement, under the federal Medicare program,
1718 including fee for service and managed care coverage;

1719 (5) "Resident day" means a day of nursing home care service
1720 provided to an individual and includes the day a resident is admitted
1721 and any day for which the nursing home is eligible for payment for
1722 reserving a resident's bed due to hospitalization or temporary leave
1723 and for the date of death. For purposes of this subdivision, a day of
1724 nursing home care service shall be the period of time between the
1725 census-taking hour in a nursing home on two successive calendar
1726 days. "Resident day" does not include a Medicare day or the day a
1727 resident is discharged;

1728 (6) "Nursing home net revenue" means amounts billed by a nursing
1729 home for all room, board and ancillary services, minus (A) contractual
1730 allowances, (B) payer discounts, (C) charity care, and (D) bad debts;
1731 and

1732 (7) "Contractual allowances" mean the amount of discounts allowed
1733 by a nursing home to certain payers from amounts billed for room,
1734 board and ancillary services.

1735 (b) (1) (A) For each calendar quarter commencing on or after July 1,
1736 2005, there is hereby imposed a resident day user fee on each nursing
1737 home in this state, which fee shall be the product of the nursing home's
1738 total resident days during the calendar quarter multiplied by the user
1739 fee, as determined by the Commissioner of Social Services pursuant to
1740 subsection (a) of section 79 of [this act] substitute house bill 6940 of the
1741 current session.

1742 (B) Commencing with the calendar quarter in which approval of the
1743 waiver of federal requirements for uniform and broad-based user fees
1744 in accordance with 42 CFR 433.68 pursuant to section [80 of this act] 82
1745 of substitute house bill 6940 of the current session is granted, the
1746 resident day user fee shall be the product of the nursing home's total

1747 resident days during the calendar quarter multiplied by the user fee, as
1748 redetermined by the Commissioner of Social Service pursuant to
1749 subsection (b) of section 79 of [this act] substitute house bill 6940 of the
1750 current session.

1751 (2) Each nursing home shall, on or before the last day of January,
1752 April, July, and October of each year, render to the commissioner a
1753 return, on forms prescribed or furnished by the commissioner, stating
1754 the nursing home's total resident days during the calendar quarter
1755 ending on the last day of the preceding month and stating such other
1756 information as the commissioner deems necessary for the proper
1757 administration of this section. The resident day user fee imposed
1758 under this section shall be due and payable on the due date of such
1759 return. Each nursing home shall be required to file such return
1760 electronically with the department and to make such payment by
1761 electronic funds transfer in the manner provided by chapter 228g of
1762 the general statutes, irrespective of whether the nursing home would
1763 have otherwise been required to file such return electronically or to
1764 make such payment by electronic funds transfer under the provisions
1765 of said chapter 228g.

1766 (c) Whenever such resident day user fee is not paid when due, a
1767 penalty of ten per cent of the amount due or fifty dollars, whichever is
1768 greater, shall be imposed, and interest at the rate of one per cent per
1769 month or fraction thereof shall accrue on such user fee from the due
1770 date of such user fee until the date of payment.

1771 (d) The commissioner shall notify the Commissioner of Social
1772 Services of any amount delinquent under this act and, upon receipt of
1773 such notice, the Commissioner of Social Services shall deduct and
1774 withhold such amount from amounts otherwise payable by the
1775 Department of Social Services to the delinquent nursing home.

1776 (e) The provisions of section 12-548, sections 12-550 to 12-554,
1777 inclusive, and section 12-555a of the general statutes shall apply to the
1778 provisions of this section in the same manner and with the same force

1779 and effect as if the language of said sections had been incorporated in
1780 full into this section and had expressly referred to the user fee imposed
1781 under this section, except to the extent that any provision is
1782 inconsistent with a provision in this section. For purposes of section
1783 12-39g of the general statutes, the resident day user fee shall be treated
1784 as a tax.

1785 (f) The commissioner may enter into an agreement with the
1786 Commissioner of Social Services delegating to the Commissioner of
1787 Social Services the authority to examine the records and returns of any
1788 nursing home subject to the resident day user fee imposed under this
1789 section and to determine whether such user fee has been underpaid or
1790 overpaid. If such authority is so delegated, examinations of such
1791 records and returns by the Department of Social Services and
1792 determinations by said department that such user fee has been
1793 underpaid or overpaid, shall have the same effect as similar
1794 examinations or determinations made by the Department of Revenue
1795 Services.

1796 (g) (1) The commissioner shall not collect the resident day user fee
1797 pursuant to this section until the Commissioner of Social Services
1798 informs the commissioner that all the necessary federal approvals are
1799 in effect to secure federal financial participation matching funds
1800 associated with the rate increases as described in section 81 of [this act]
1801 substitute house bill 6940 of the current session.

1802 (2) The commissioner shall cease to collect the resident day user fee
1803 pursuant to this section if the Commissioner of Social Services informs
1804 the commissioner that the federal approvals described in subdivision
1805 (1) of this subsection are withheld or withdrawn.

1806 Sec. 48. Section 79 of substitute house bill 6940 of the current session
1807 is repealed and the following is substituted in lieu thereof (*Effective July*
1808 *1, 2005*):

1809 (a) On or before July 1, 2005, and on or before July [1] first of each
1810 succeeding calendar year, the Commissioner of Social Services shall

1811 determine the amount of the user fee and promptly notify the
1812 commissioner and nursing homes of such amount. The user fee shall
1813 be the (1) the sum of each nursing home's anticipated nursing home
1814 net revenue, including but not limited to its estimated net revenue
1815 from any increases in Medicaid payments, during the twelve-month
1816 period ending on June [30] thirtieth of the succeeding calendar year, (2)
1817 which sum shall be multiplied by six per cent, and (3) which product
1818 shall be divided by the sum of each nursing home's anticipated
1819 resident days during the twelve-month period ending on June [30]
1820 thirtieth of the succeeding calendar year. The Commissioner of Social
1821 Services, in anticipating nursing home net revenue and resident days,
1822 shall use the most recently available nursing home net revenue and
1823 resident day information.

1824 (b) Upon approval of the waiver of federal requirements for
1825 uniform and broad-based user fees in accordance with 42 CFR 433.68
1826 pursuant to section [81 of this act] 82 of substitute house bill 6940 of the
1827 current session, the Commissioner of Social Services shall redetermine
1828 the amount of the user fee and promptly notify the commissioner and
1829 nursing homes of such amount. The user fee shall be the (1) the sum of
1830 each nursing home's anticipated nursing home net revenue, including
1831 but not limited to its estimated net revenue from any increases in
1832 Medicaid payments, during the twelve-month period ending on June
1833 [30] thirtieth of the succeeding calendar year but not including any
1834 such anticipated net revenue of any nursing home exempted from such
1835 user fee due to waiver of federal requirements pursuant to section [4 of
1836 this act] 82 of substitute house bill 6940 of the current session, (2)
1837 which sum shall be multiplied by six per cent, and (3) which product
1838 shall be divided by the sum of each nursing home's anticipated
1839 resident days, but not including the anticipated resident days of any
1840 nursing home exempted from such user fee due to waiver of federal
1841 requirements pursuant to section [81 of this act] 82 of substitute house
1842 bill 6940 of the current session. Notwithstanding the provisions of this
1843 subsection, the amount of the user fee for each nursing home licensed
1844 for more than two hundred thirty beds or owned by a municipality

1845 shall be equal to the amount necessary to comply with federal provider
1846 tax uniformity waiver requirements as determined by the
1847 Commissioner of Social Services. The Commissioner of Social Services
1848 may increase retroactively the user fee for nursing homes not licensed
1849 for more than two hundred thirty beds and not owned by a
1850 municipality to the effective date of waiver of said federal
1851 requirements to offset user fee reductions necessary to meet the federal
1852 waiver requirements. Thereafter, on or before July 1 of each succeeding
1853 calendar year, the Commissioner of Social Services shall determine the
1854 amount of the user fee in accordance with this subsection. The
1855 Commissioner of Social Services, in anticipating nursing home net
1856 revenue and resident days, shall use the most recently available
1857 nursing home net revenue and resident day information.

1858 (c) (1) Following a redetermination of the resident day user fee by
1859 the Commissioner of Social Services pursuant to subsection (b) of this
1860 section, the Commissioner of Social Services shall notify the
1861 commissioner of the identity of (A) any nursing home subsequently
1862 exempted from the resident day user fee due to the waiver of federal
1863 requirements pursuant to section [81 of this act] 82 of substitute house
1864 bill 6940 of the current session and the effective date of such waiver,
1865 (B) any nursing home licensed for more than two hundred thirty beds
1866 or owned by a municipality and the effective date of any change in its
1867 user fee, and (C) any nursing home for which the user fee is
1868 retroactively increased pursuant to subsection (b) of this section and
1869 the effective date of such increase. The Commissioner of Social
1870 Services shall provide notice of any such retroactive user fee increase
1871 to each nursing home so affected.

1872 (2) Upon being notified by the Commissioner of Social Services, the
1873 commissioner shall refund or credit to any nursing home subsequently
1874 exempted from the resident day user fee due to the waiver of federal
1875 requirements pursuant to section [81 of this act] 82 of substitute house
1876 bill 6940 of the current session any resident day user fee collected from
1877 such home. No interest shall be payable on the amount of such refund
1878 or credit. Any such nursing home shall refund any fees paid by or on

1879 behalf of any resident to the party making such payment.

1880 (3) Upon being notified by the Commissioner of Social Services, the
1881 commissioner shall refund or credit to any nursing home licensed for
1882 more than two hundred thirty beds or owned by a municipality any
1883 resident day user fee collected from such home in excess of the
1884 resident day user fee that would have been payable had the user fee, as
1885 redetermined by the Commissioner of Social Services, been used in
1886 calculating the nursing home's resident day user fee. No interest shall
1887 be payable on the amount of such refund or credit.

1888 (4) Upon being notified by the Commissioner of Social Services, the
1889 commissioner shall notify any nursing home for which the user fee is
1890 retroactively increased pursuant to subsection (b) of this section of the
1891 additional amount of resident day user fee due and owing from such
1892 nursing home. Such a notice of additional amount due and owing to
1893 the commissioner shall not be treated as a notice of deficiency
1894 assessment by the commissioner nor shall the nursing home have,
1895 based on such notice of additional amount due, any right of protest or
1896 appeal to the commissioner as in the case of such a deficiency
1897 assessment. No interest shall be payable on such additional amount to
1898 the extent such additional amount is paid on or before the last day of
1899 the month next succeeding the month during which the Commissioner
1900 of Social Services provided notice of such retroactive user fee increase
1901 to such nursing home.

1902 Sec. 49. Subdivision (4) of subsection (f) of section 17b-340 of the
1903 general statutes, as amended by section 81 of substitute house bill 6940
1904 of the current session, is repealed and the following is substituted in
1905 lieu thereof (Effective July 1, 2005):

1906 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
1907 receive a rate that is less than the rate it received for the rate year
1908 ending June 30, 1991; (B) no facility whose rate, if determined pursuant
1909 to this subsection, would exceed one hundred twenty per cent of the
1910 state-wide median rate, as determined pursuant to this subsection,

1911 shall receive a rate which is five and one-half per cent more than the
1912 rate it received for the rate year ending June 30, 1991; and (C) no
1913 facility whose rate, if determined pursuant to this subsection, would be
1914 less than one hundred twenty per cent of the state-wide median rate,
1915 as determined pursuant to this subsection, shall receive a rate which is
1916 six and one-half per cent more than the rate it received for the rate year
1917 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
1918 facility shall receive a rate that is less than the rate it received for the
1919 rate year ending June 30, 1992, or six per cent more than the rate it
1920 received for the rate year ending June 30, 1992. For the fiscal year
1921 ending June 30, 1994, no facility shall receive a rate that is less than the
1922 rate it received for the rate year ending June 30, 1993, or six per cent
1923 more than the rate it received for the rate year ending June 30, 1993.
1924 For the fiscal year ending June 30, 1995, no facility shall receive a rate
1925 that is more than five per cent less than the rate it received for the rate
1926 year ending June 30, 1994, or six per cent more than the rate it received
1927 for the rate year ending June 30, 1994. For the fiscal years ending June
1928 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
1929 than three per cent more than the rate it received for the prior rate
1930 year. For the fiscal year ending June 30, 1998, a facility shall receive a
1931 rate increase that is not more than two per cent more than the rate that
1932 the facility received in the prior year. For the fiscal year ending June
1933 30, 1999, a facility shall receive a rate increase that is not more than
1934 three per cent more than the rate that the facility received in the prior
1935 year and that is not less than one per cent more than the rate that the
1936 facility received in the prior year, exclusive of rate increases associated
1937 with a wage, benefit and staffing enhancement rate adjustment added
1938 for the period from April 1, 1999, to June 30, 1999, inclusive. For the
1939 fiscal year ending June 30, 2000, each facility, except a facility with an
1940 interim rate or replaced interim rate for the fiscal year ending June 30,
1941 1999, and a facility having a certificate of need or other agreement
1942 specifying rate adjustments for the fiscal year ending June 30, 2000,
1943 shall receive a rate increase equal to one per cent applied to the rate the
1944 facility received for the fiscal year ending June 30, 1999, exclusive of
1945 the facility's wage, benefit and staffing enhancement rate adjustment.

1946 For the fiscal year ending June 30, 2000, no facility with an interim rate,
1947 replaced interim rate or scheduled rate adjustment specified in a
1948 certificate of need or other agreement for the fiscal year ending June
1949 30, 2000, shall receive a rate increase that is more than one per cent
1950 more than the rate the facility received in the fiscal year ending June
1951 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
1952 facility with an interim rate or replaced interim rate for the fiscal year
1953 ending June 30, 2000, and a facility having a certificate of need or other
1954 agreement specifying rate adjustments for the fiscal year ending June
1955 30, 2001, shall receive a rate increase equal to two per cent applied to
1956 the rate the facility received for the fiscal year ending June 30, 2000,
1957 subject to verification of wage enhancement adjustments pursuant to
1958 subdivision (15) of this subsection. For the fiscal year ending June 30,
1959 2001, no facility with an interim rate, replaced interim rate or
1960 scheduled rate adjustment specified in a certificate of need or other
1961 agreement for the fiscal year ending June 30, 2001, shall receive a rate
1962 increase that is more than two per cent more than the rate the facility
1963 received for the fiscal year ending June 30, 2000. For the fiscal year
1964 ending June 30, 2002, each facility shall receive a rate that is two and
1965 one-half per cent more than the rate the facility received in the prior
1966 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
1967 receive a rate that is two per cent more than the rate the facility
1968 received in the prior fiscal year, except that such increase shall be
1969 effective January 1, 2003, and such facility rate in effect for the fiscal
1970 year ending June 30, 2002, shall be paid for services provided until
1971 December 31, 2002, except any facility that would have been issued a
1972 lower rate effective July 1, 2002, than for the fiscal year ending June 30,
1973 2002, due to interim rate status or agreement with the department shall
1974 be issued such lower rate effective July 1, 2002, and have such rate
1975 increased two per cent effective June 1, 2003. For the fiscal year ending
1976 June 30, 2004, rates in effect for the period ending June 30, 2003, shall
1977 remain in effect, except any facility that would have been issued a
1978 lower rate effective July 1, 2003, than for the fiscal year ending June 30,
1979 2003, due to interim rate status or agreement with the department shall
1980 be issued such lower rate effective July 1, 2003. For the fiscal year

1981 ending June 30, 2005, rates in effect for the period ending June 30, 2004,
1982 shall remain in effect until December 31, 2004, except any facility that
1983 would have been issued a lower rate effective July 1, 2004, than for the
1984 fiscal year ending June 30, 2004, due to interim rate status or
1985 agreement with the department shall be issued such lower rate
1986 effective July 1, 2004. Effective January 1, 2005, each facility shall
1987 receive a rate that is one per cent greater than the rate in effect
1988 December 31, 2004. Effective upon receipt of all the necessary federal
1989 approvals to secure federal financial participation matching funds
1990 associated with the rate increase provided in this subdivision, but in
1991 no event earlier than July 1, 2005, and provided the user fee imposed
1992 under section 78 of [this act] substitute house bill 6940 of the current
1993 session is required to be collected, for the fiscal year ending June 30,
1994 2006, the department shall compute the rate for each facility based
1995 upon its 2003 cost report filing or, a subsequent cost year filing for
1996 facilities having an interim rate for the period ending June 30, 2005 as
1997 provided under Section 17-311-55 of the Regulations of Connecticut
1998 State Agencies. For each facility not having an interim rate for the
1999 period ending June 30, 2005, the rate for the period ending June 30,
2000 2006 shall be determined beginning with the higher of the computed
2001 rate based upon its 2003 cost report filing or the rate in effect for the
2002 period ending June 30, 2005. Such rate shall then be increased by
2003 \$11.80 per day except that in no event shall the rate for the period
2004 ending June 30, 2006 be \$32.00 more than the rate in effect for the
2005 period ending June 30, 2005 and for any facility with a rate below
2006 \$195.00 per day for the period ending June 30, 2005 such rate for the
2007 period ending June 30, 2006 shall not be greater than \$217.43 per day
2008 and for any facility with a rate equal to or greater than \$195.00 per day
2009 for the period ending June 30, 2005 such rate for the period ending
2010 June 30, 2006 shall not exceed the rate in effect for the period ending
2011 June 30, 2005 increased by eleven and one-half per cent. For each
2012 facility with an interim rate for the period ending June 30, 2005, the
2013 interim replacement rate for the period ending June 30, 2006 shall not
2014 exceed the rate in effect for the period ending June 30, 2005 increased
2015 by \$11.80 per day plus the per day cost of the user fee payments made

2016 pursuant to [Section] section 78 of [this act] substitute house bill 6940
2017 of the current session divided by annual resident service days, except
2018 for any facility with an interim rate below \$195.00 per day for the
2019 period ending June 30, 2005 the interim replacement rate for the period
2020 ending June 30, 2006 shall not be greater than \$217.43 per day and for
2021 any facility with an interim rate equal to or greater than \$195.00 per
2022 day for the period ending June 30, 2005 the interim replacement rate
2023 for the period ending June 30, 2006 shall not exceed the rate in effect
2024 for the period ending June 30, 2005 increased by eleven and one-half
2025 per cent. Such July 1, 2005, rate adjustments shall remain in effect
2026 unless (i) the federal financial participation matching funds associated
2027 with the rate increase are no longer available; or (ii) the user fee
2028 created pursuant to section 78 of substitute house bill 6940 of the
2029 current session is not in effect. For fiscal year ending June 30, 2007, all
2030 facility rates in effect for the period ending June 30, 2006, shall remain
2031 in effect, except for any facility that would have been issued a lower rate
2032 effective July 1, 2006, than for the rate period ending June 30, 2006, due
2033 to interim rate status or agreement with the department, shall be
2034 issued such lower rate effective July 1, 2006. The Commissioner of
2035 Social Services shall add fair rent increases to any other rate increases
2036 established pursuant to this subdivision for a facility which has
2037 undergone a material change in circumstances related to fair rent.
2038 Interim rates may take into account reasonable costs incurred by a
2039 facility, including wages and benefits.

2040 Sec. 50. Section 82 of substitute house bill 6940 of the current session
2041 is repealed and the following is substituted in lieu thereof (*Effective July*
2042 *1, 2005*) :

2043 Not later than fifteen days after approval of the Medicaid state plan
2044 amendment required to implement section 81 of [this act] substitute
2045 house bill 6940 of the current session, the Commissioner of Social
2046 Services shall seek approval from the Centers for Medicare and
2047 Medicaid Services for, and shall file a provider user fee uniformity
2048 waiver request regarding, the user fee set forth in [this act] substitute
2049 house bill 6940 of the current session. The request for approval shall

2050 include a request for a waiver of federal requirements for uniform and
2051 broad-based user fees in accordance with 42 CFR 433.68, to (1) exempt
2052 from the user fee prescribed by section 78 of [this act] substitute house
2053 bill 6940 of the current session any [nursing facility owned by an entity
2054 that provides continuing care in exchange for a transfer of assets or an
2055 entrance fee in addition to or in lieu of periodic payments, regardless
2056 of whether such nursing facility participates in the Medicaid program]
2057 nusing home that is owned and operated as of May 1, 2005, by the
2058 legal entity that is registered as a continuing care facility with the
2059 Department of Social Services, in accordance with section 17b-521,
2060 regardless of whether such nursing home participants in the Medicaid
2061 program and any nursing home licensed after May 1, 2005, that is
2062 owned and operated by the legal entity that is registered as a
2063 continuing care facility with the Department of Social Services in
2064 accordance with section 17b-521; and (2) impose a user fee in an
2065 amount less than the fee determined pursuant to section 78 of this act
2066 as necessary to meet the requirements of 42 CFR 433.68(e)(2) on (A)
2067 nursing homes owned by a municipality and (B) nursing homes
2068 licensed for more than 230 beds. Notwithstanding any section of the
2069 general statutes, the provisions of section 17b-8 of the general statutes
2070 shall not apply to the waiver sought pursuant to this section.

2071 Sec. 51. Subdivision (1) of subsection (h) of section 17b-340 of the
2072 general statutes, as amended by section 84 of substitute house bill 6940
2073 of the current session, is repealed and the following is substituted in
2074 lieu thereof (*Effective July 1, 2005*):

2075 (h) (1) For the fiscal year ending June 30, 1993, any residential care
2076 home with an operating cost component of its rate in excess of one
2077 hundred thirty per cent of the median of operating cost components of
2078 rates in effect January 1, 1992, shall not receive an operating cost
2079 component increase. For the fiscal year ending June 30, 1993, any
2080 residential care home with an operating cost component of its rate that
2081 is less than one hundred thirty per cent of the median of operating cost
2082 components of rates in effect January 1, 1992, shall have an allowance
2083 for real wage growth equal to sixty-five per cent of the increase

determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall

2119 be based upon the increased allowable salary of an administrator,
2120 regardless of whether such amount was expended in the 2000 cost
2121 report period upon which the rates are based. Beginning with the fiscal
2122 year ending June 30, 2000, the inflation adjustment for rates made in
2123 accordance with subsection (p) of section 17-311-52 of the regulations
2124 of Connecticut state agencies shall be increased by two per cent, and
2125 beginning with the fiscal year ending June 30, 2002, the inflation
2126 adjustment for rates made in accordance with subsection (c) of said
2127 section shall be increased by one per cent. Beginning with the fiscal
2128 year ending June 30, 1999, for the purpose of determining the
2129 allowable salary of a related party, the department shall revise the
2130 maximum salary to twenty-seven thousand eight hundred fifty-six
2131 dollars to be annually inflated thereafter in accordance with section
2132 17-311-52 of the regulations of Connecticut state agencies and
2133 beginning with the fiscal year ending June 30, 2001, such allowable
2134 salary shall be computed on an hourly basis and the maximum
2135 number of hours allowed for a related party other than the proprietor
2136 shall be increased from forty hours to forty-eight hours per work week.
2137 For the fiscal year ending June 30, 2005, each facility shall receive a rate
2138 that is two and one-quarter per cent more than the rate the facility
2139 received in the prior fiscal year, except any facility that would have
2140 been issued a lower rate effective July 1, 2004, than for the fiscal year
2141 ending June 30, 2004, due to interim rate status or agreement with the
2142 department shall be issued such lower rate effective July 1, 2004.
2143 Effective upon receipt of all the necessary federal approvals to secure
2144 federal financial participation matching funds associated with the rate
2145 increase provided in subdivision (4) of subsection (f) of this section, as
2146 amended by this act, but in no event earlier than October 1, 2005, and
2147 provided the user fee imposed under section 78 of [this act] substitute
2148 house bill 6940 of the current session is required to be collected, each
2149 facility shall receive a rate that is [four per cent more than the rate the
2150 facility received in the prior fiscal year] determined in accordance with
2151 applicable law and subject to appropriations, except any facility that
2152 would have been issued a lower rate effective October 1, 2005, than for
2153 the fiscal year ending June 30, 2005, due to interim rate status or

2154 agreement with the department, shall be issued such lower rate
2155 effective October 1, 2005. Such rate increase shall remain in effect
2156 unless: (A) The federal financial participation matching funds
2157 associated with the rate increase are no longer available; or (B) the user
2158 fee created pursuant to section 78 of [this act] substitute house bill 6940
2159 of the current session is not in effect. For the fiscal year ending June 30,
2160 2007, rates in effect for the period ending June 30, 2006, shall remain in
2161 effect, except any facility that would have been issued a lower rate
2162 effective July 1, 2006, than for the fiscal year ending June 30, 2006, due
2163 to interim rate status or agreement with the department, shall be
2164 issued such lower rate effective July 1, 2006.

2165 Sec. 52. Section 85 of substitute house bill 6940 of the current session
2166 is repealed and the following is substituted in lieu thereof (*Effective July*
2167 *1, 2005*):

2168 For the fiscal year ending June 30, 2006, any nursing home that
2169 receives a net gain in revenue [shall apply at least eighty five per cent
2170 of such net gain to increased employee wage rates and benefits and
2171 additional direct and indirect component staffing. Such net gain] shall
2172 not be applied to wage and salary increases provided to the
2173 administrator, assistant administrator, owners or related party
2174 employees. For the purposes of this section, "net gain in revenue"
2175 means the difference between the rate in effect June 30, 2005, and the
2176 rate in effect on July 1, 2005, multiplied by the number of resident days
2177 eligible for state payment for the period between July 1, 2005, and June
2178 30, 2006, less [state revenue taxes] resident day user fees accrued for
2179 the period between July 1, 2005, and June 30, 2006. The Commissioner
2180 of Social Services [shall] may compare expenditures for wages,
2181 [benefits and staffing] and salary increases provided to administrators,
2182 assistant administrators, owners or related party employees for the
2183 fiscal year ending June 30, 2006, [exclusive of administrator, assistant
2184 administrator, owners or related party employee expenditures,] to
2185 such expenditures in the year ending June 30, 2005, to verify [whether
2186 a facility has applied at least eighty five per cent of its net gain to
2187 specified wage, benefit and staffing enhancements] compliance with

2188 this section. In the event that the commissioner determines that a
2189 facility did [not] apply [at least eighty five per cent of its net gain to
2190 such specified enhancements] its net gain in revenue to wage and
2191 salary increases for administrators, assistant administrators, owners or
2192 related party employees, the commissioner shall recover such amounts
2193 from the facility through rate adjustments or other means. The
2194 commissioner may require facilities to file cost reporting forms, in
2195 addition to the annual cost report, as may be necessary, to verify the
2196 appropriate application of any net gain.

2197 Sec. 53. (NEW) (*Effective January 1, 2007*) (a) There is established a
2198 Department on Aging which shall be under the direction and
2199 supervision of the Commissioner on Aging who shall be appointed by
2200 the Governor in accordance with the provisions of sections 4-5 to 4-8,
2201 inclusive, of the general statutes with the powers and duties prescribed
2202 in said sections. The commissioner shall be knowledgeable and
2203 experienced with respect to the conditions and needs of elderly
2204 persons and shall serve on a full-time basis.

2205 (b) The Commissioner on Aging shall administer all laws under the
2206 jurisdiction of the Department on Aging and shall employ the most
2207 efficient and practical means for the provision of care and protection of
2208 elderly persons. The commissioner shall have the power and duty to
2209 do the following: (1) Administer, coordinate and direct the operation
2210 of the department; (2) adopt and enforce regulations, in accordance
2211 with chapter 54 of the general statutes, as necessary to implement the
2212 purposes of the department as established by statute; (3) establish rules
2213 for the internal operation and administration of the department; (4)
2214 establish and develop programs and administer services to achieve the
2215 purposes of the department; (5) contract for facilities, services and
2216 programs to implement the purposes of the department; (6) act as
2217 advocate for necessary additional comprehensive and coordinated
2218 programs for elderly persons; (7) assist and advise all appropriate
2219 state, federal, local and area planning agencies for elderly persons in
2220 the performance of their functions and duties pursuant to federal law
2221 and regulation; (8) plan services and programs for elderly persons; (9)

2222 coordinate outreach activities by public and private agencies serving
2223 elderly persons; and (10) consult and cooperate with area and private
2224 planning agencies.

2225 (c) The functions, powers, duties and personnel of the Division of
2226 Elderly Services of the Department of Social Services, or any
2227 subsequent division or portion of a division with similar functions,
2228 powers, personnel and duties, shall be transferred to the Department
2229 on Aging pursuant to the provisions of sections 4-38d, 4-38e and 4-39
2230 of the general statutes.

2231 (d) Any order or regulation of the Department of Social Services or
2232 the Commission on Aging that is in force on January 1, 2007, shall
2233 continue in force and effect as an order or regulation until amended,
2234 repealed or superseded pursuant to law.

2235 Sec. 54. (*Effective July 1, 2005*) (a) There is established a task force to
2236 study the reestablishment of the Department on Aging pursuant to this
2237 act. The task force shall study the provisions of this act and shall make
2238 recommendations on revisions to the general statutes and other
2239 changes necessary or advisable to implement the provisions of this act.

2240 (b) The task force shall consist of the following members:

2241 (1) One appointed by the speaker of the House of Representatives;

2242 (2) One appointed by the president pro tempore of the Senate;

2243 (3) One appointed by the majority leader of the House of
2244 Representatives;

2245 (4) One appointed by the majority leader of the Senate;

2246 (5) One appointed by the minority leader of the House of
2247 Representatives;

2248 (6) One appointed by the minority leader of the Senate;

2249 (7) The chairpersons, vice chairpersons and ranking members of the

2250 select committee of the General Assembly having cognizance of
2251 matters relating to aging;

2252 (8) Two appointed by the Governor;

2253 (9) The Secretary of the Office of Policy and Management, or the
2254 secretary's designee; and

2255 (10) The Commissioners of Social Services, Public Health, Mental
2256 Health and Addiction Services and Transportation and the Chief
2257 State's Attorney, or their designees.

2258 (c) Any member of the task force appointed under subdivision (1),
2259 (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member
2260 of the General Assembly.

2261 (d) All appointments to the task force shall be made no later than
2262 thirty days after the effective date of this section. If an appointment is
2263 not made by the expiration of said thirty-day period, the chairpersons,
2264 vice-chairpersons and ranking members of the select committee of the
2265 General Assembly having cognizance of matters relating to aging may
2266 make the appointment. Any vacancy shall be filled by the appointing
2267 authority.

2268 (e) The speaker of the House of Representatives and the president
2269 pro tempore of the Senate shall select the chairpersons of the task
2270 force, from among the members of the task force. Such chairpersons
2271 shall schedule the first meeting of the task force, which shall be held no
2272 later than sixty days after the effective date of this section.

2273 (f) The administrative staff of the select committee of the General
2274 Assembly having cognizance of matters relating to aging shall serve as
2275 administrative staff of the task force.

2276 (g) Not later than February 15, 2006, the task force shall submit a
2277 report on its findings and recommendations to the select committee of
2278 the General Assembly having cognizance of matters relating to aging,
2279 in accordance with the provisions of section 11-4a of the general

2280 statutes. The task force shall terminate on the date that it submits such
2281 report or January 1, 2007, whichever is earlier.

2282 Sec. 55. (*Effective from passage*) During the fiscal year ending June 30,
2283 2006, the Commissioner of Social Services shall, within existing
2284 budgetary resources, in an amount not to exceed one hundred
2285 thousand dollars, provide grants not to exceed twenty-five thousand
2286 dollars for each grant, to four municipalities with populations of
2287 twenty-five thousand or more, or to a nonprofit organization located
2288 within any such municipality. Such grants shall be used by such
2289 municipality or nonprofit organization to develop and plan financially
2290 self-sustaining community-based regional transportation systems that,
2291 through a combination of private donations and user fees, provide
2292 transportation services on behalf of elderly persons. Prior to the
2293 disbursement of any grant made pursuant to this section, a
2294 municipality selected to receive such grant shall demonstrate to the
2295 satisfaction of the commissioner, that such municipality has secured
2296 additional private funds, in an amount of not less than twenty-five
2297 thousand dollars that shall be used to develop and plan financially
2298 self-sustaining community-based regional transportation systems. Any
2299 municipality selected to receive a grant pursuant to this section shall,
2300 to the extent practicable, model such community-based regional
2301 transportation system on the ITNAmerica model and shall work
2302 cooperatively with the regional planning agency of which the
2303 municipality is a member in planning and developing such
2304 community-based regional transportation system.

2305 Sec. 56. Section 8-3e of the general statutes is repealed and the
2306 following is substituted in lieu thereof (*Effective July 1, 2005*):

2307 (a) No zoning regulation shall treat the following in a manner
2308 different from any single family residence: (1) Any community
2309 residence [which] that houses six or fewer mentally retarded persons
2310 and necessary staff persons and [which] that is licensed under the
2311 provisions of section 17a-227, [or] (2) any child-care residential facility
2312 [which] that houses six or fewer children with mental or physical

2313 disabilities and necessary staff persons and [which] that is licensed
2314 under sections 17a-145 to 17a-151, inclusive, or (3) any community
2315 residence that houses six or fewer persons receiving mental health or
2316 addiction services and necessary staff persons paid for or provided by
2317 the Department of Mental Health and Addiction Services and that has
2318 been issued a license by the Department of Public Health under the
2319 provisions of section 19a-491, if a license is required.

2320 (b) Any resident of a municipality in which such a community
2321 residence or child-care residential facility is located may, with the
2322 approval of the legislative body of such municipality, petition (1) the
2323 Commissioner of Mental Retardation to revoke the license of such
2324 community residence on the grounds that such community residence
2325 is not in compliance with the provisions of any statute or regulation
2326 concerning the operation of such residences, [or] (2) the Commissioner
2327 of Children and Families to revoke the license of such child-care
2328 residential facility on the grounds that such child-care residential
2329 facility is not in compliance with the provision of any general statute
2330 or regulation concerning the operation of such child-care residential
2331 facility, or (3) the Commissioner of Mental Health and Addiction
2332 Services to withdraw funding from such community residence on the
2333 grounds that such community residence is not in compliance with the
2334 provisions of any general statute or regulation adopted thereunder
2335 concerning the operation of a community residence.

2336 Sec. 57. (NEW) (*Effective July 1, 2005*) (a) There is established a board
2337 of directors to advise the Department of Public Health on the
2338 operations of the critical access hospital. The board shall consist of the
2339 following members: The Commissioners of Public Health, Emergency
2340 Management and Homeland Security, Public Safety and Social
2341 Services, or their designees, the Secretary of the Office of Policy and
2342 Management, or the secretary's designee, the Adjutant General, or the
2343 Adjutant General's designee, one representative of a hospital in this
2344 state with more than five hundred licensed beds and one
2345 representative of a hospital in this state with five hundred or fewer
2346 licensed beds, both appointed by the Commissioner of Public Health.

2347 The Commissioner of Public Health shall be the chairperson of the
2348 board. The board shall adopt bylaws and shall meet at such times as
2349 specified in such bylaws and at such other times as the Commissioner
2350 of Public Health deems necessary.

2351 (b) The board shall advise the department on matters, including, but
2352 not limited to: Operating policies and procedures; facility deployment
2353 and operation; appropriate utilization of the facility; clinical programs
2354 and delivery of patient health care services; hospital staffing patterns
2355 and staff-to-patient ratios; human resources policies; standards and
2356 accreditation guidelines; credentialing of clinical and support staff;
2357 patient admission, transfer and discharge policies and procedures;
2358 quality assurance and performance improvement; patient rates and
2359 billing and reimbursement mechanisms; staff education and training
2360 requirements and alternative facility uses.

2361 Sec. 58. Subsection (a) of section 19a-638 of the general statutes, as
2362 amended by section 1 of public act 05-93, is repealed and the following
2363 is substituted in lieu thereof (*Effective July 1, 2005*):

2364 (a) Except as provided in sections 19a-639a to 19a-639c, inclusive,
2365 and section 59 of this act:

2366 (1) Each health care facility or institution, that intends to (A) transfer
2367 all or part of its ownership or control, (B) change the governing powers
2368 of the board of a parent company or an affiliate, whatever its
2369 designation, or (C) change or transfer the powers or control of a
2370 governing or controlling body of an affiliate, shall submit to the office,
2371 prior to the proposed date of such transfer or change, a request for
2372 permission to undertake such transfer or change.

2373 (2) Each health care facility or institution or state health care facility
2374 or institution, including any inpatient rehabilitation facility, which
2375 intends to introduce any additional function or service into its
2376 program of health care shall submit to the office, prior to the proposed
2377 date of the institution of such function or service, a request for
2378 permission to undertake such function or service.

2379 (3) Each health care facility or institution or state health care facility
2380 or institution which intends to terminate a health service offered by
2381 such facility or institution or reduce substantially its total bed capacity,
2382 shall submit to the office, prior to the proposed date of such
2383 termination or decrease, a request to undertake such termination or
2384 decrease.

2385 (4) Except as provided in sections 19a-639a to 19a-639c, inclusive,
2386 each applicant, prior to submitting a certificate of need application
2387 under this section, section 19a-639 or under both sections, shall submit
2388 a request, in writing, for application forms and instructions to the
2389 office. The request shall be known as a letter of intent. A letter of intent
2390 shall include: (A) The name of the applicant or applicants; (B) a
2391 statement indicating whether the application is for (i) a new,
2392 replacement or additional facility, service or function, (ii) the
2393 expansion or relocation of an existing facility, service or function, (iii) a
2394 change in ownership or control, (iv) a termination of a service or a
2395 reduction in total bed capacity and the bed type, (v) any new or
2396 additional beds and their type, (vi) a capital expenditure over one
2397 million dollars, (vii) the purchase, lease or donation acceptance of
2398 major medical equipment costing over four hundred thousand dollars,
2399 (viii) a CT scanner, PET scanner, PET/CT scanner, MRI scanner,
2400 cineangiography equipment, a linear accelerator or other similar
2401 equipment utilizing technology that is new or being introduced into
2402 the state, or (ix) any combination thereof; (C) the estimated capital cost,
2403 value or expenditure; (D) the town where the project is or will be
2404 located; and (E) a brief description of the proposed project. The office
2405 shall provide public notice of any complete letter of intent submitted
2406 under this section, section 19a-639, or both, by publication in a
2407 newspaper having a substantial circulation in the area served or to be
2408 served by the applicant. Such notice shall be submitted for publication
2409 not later than fifteen business days after a determination that a letter of
2410 intent is complete. No certificate of need application will be considered
2411 submitted to the office unless a current letter of intent, specific to the
2412 proposal and in compliance with this subsection, has been on file with

2413 the office at least sixty days. A current letter of intent is a letter of
2414 intent that has been on file at the office up to and including one
2415 hundred twenty days, except that an applicant may request a one-time
2416 extension of a letter of intent of up to an additional thirty days for a
2417 maximum total of up to one hundred fifty days if, prior to the
2418 expiration of the current letter of intent, the office receives a written
2419 request to so extend the letter of intent's current status. The extension
2420 request shall fully explain why an extension is requested. The office
2421 shall accept or reject the extension request not later than five business
2422 days from the date it receives such request and shall so notify the
2423 applicant.

2424 Sec. 59. (NEW) (*Effective July 1, 2005*) Any additional critical access
2425 hospital beds and related equipment obtained for the purpose of
2426 enhancing the state's bed surge capacity or providing isolation care
2427 under the state's public health preparedness planning and response
2428 activities shall be exempt from the provisions of subdivision (2) of
2429 subsection (a) of section 19a-638 of the general statutes, as amended by
2430 this act.

2431 Sec. 60. Section 19a-490 of the general statutes is repealed and the
2432 following is substituted in lieu thereof (*Effective July 1, 2005*):

2433 As used in this chapter and sections 57, 59 and 64 to 67, inclusive, of
2434 this act:

2435 (a) "Institution" means a hospital, residential care home, health care
2436 facility for the handicapped, nursing home, rest home, home health
2437 care agency, homemaker-home health aide agency, mental health
2438 facility, substance abuse treatment facility, outpatient surgical facility,
2439 an infirmary operated by an educational institution for the care of
2440 students enrolled in, and faculty and employees of, such institution; a
2441 facility engaged in providing services for the prevention, diagnosis,
2442 treatment or care of human health conditions, including facilities
2443 operated and maintained by any state agency, except facilities for the
2444 care or treatment of mentally ill persons or persons with substance

2445 abuse problems; and a residential facility for the mentally retarded
2446 licensed pursuant to section 17a-227 and certified to participate in the
2447 Title XIX Medicaid program as an intermediate care facility for the
2448 mentally retarded;

2449 (b) "Hospital" means an establishment for the lodging, care and
2450 treatment of persons suffering from disease or other abnormal physical
2451 or mental conditions and includes inpatient psychiatric services in
2452 general hospitals;

2453 (c) "Residential care home", "nursing home" or "rest home" means an
2454 establishment which furnishes, in single or multiple facilities, food and
2455 shelter to two or more persons unrelated to the proprietor and, in
2456 addition, provides services which meet a need beyond the basic
2457 provisions of food, shelter and laundry;

2458 (d) "Home health care agency" means a public or private
2459 organization, or a subdivision thereof, engaged in providing
2460 professional nursing services and the following services, available
2461 twenty-four hours per day, in the patient's home or a substantially
2462 equivalent environment: Homemaker-home health aide services as
2463 defined in this section, physical therapy, speech therapy, occupational
2464 therapy or medical social services. The agency shall provide
2465 professional nursing services and at least one additional service
2466 directly and all others directly or through contract. An agency shall be
2467 available to enroll new patients seven days a week, twenty-four hours
2468 per day;

2469 (e) "Homemaker-home health aide agency" means a public or
2470 private organization, except a home health care agency, which
2471 provides in the patient's home or a substantially equivalent
2472 environment supportive services which may include, but are not
2473 limited to, assistance with personal hygiene, dressing, feeding and
2474 incidental household tasks essential to achieving adequate household
2475 and family management. Such supportive services shall be provided
2476 under the supervision of a registered nurse and, if such nurse

2477 determines appropriate, shall be provided by a social worker, physical
2478 therapist, speech therapist or occupational therapist. Such supervision
2479 may be provided directly or through contract;

2480 (f) "Homemaker-home health aide services" as defined in this
2481 section shall not include services provided to assist individuals with
2482 activities of daily living when such individuals have a disease or
2483 condition that is chronic and stable as determined by a physician
2484 licensed in the state of Connecticut;

2485 (g) "Mental health facility" means any facility for the care or
2486 treatment of mentally ill or emotionally disturbed adults, or any
2487 mental health outpatient treatment facility that provides treatment to
2488 persons sixteen years of age or older who are receiving services from
2489 the Department of Mental Health and Addiction Services, but does not
2490 include family care homes for the mentally ill;

2491 (h) "Alcohol or drug treatment facility" means any facility for the
2492 care or treatment of persons suffering from alcoholism or other drug
2493 addiction;

2494 (i) "Person" means any individual, firm, partnership, corporation,
2495 limited liability company or association;

2496 (j) "Commissioner" means the Commissioner of Public Health;

2497 (k) "Home health agency" means an agency licensed as a home
2498 health care agency or a homemaker-home health aide agency; [and]

2499 (l) "Assisted living services agency" means an institution that
2500 provides, among other things, nursing services and assistance with
2501 activities of daily living to a population that is chronic and stable; and

2502 (m) "Critical access hospital" means a facility used intermittently,
2503 deployed at the discretion of the Governor, or the Governor's designee,
2504 for the purpose of training or in the event of a public health or other
2505 emergency for isolation care purposes or triage and treatment during a
2506 mass casualty event.

2507 Sec. 61. Section 19a-630 of the general statutes is repealed and the
2508 following is substituted in lieu thereof (*Effective July 1, 2005*):

2509 As used in this chapter:

2510 (1) "Health care facility or institution" means any facility or
2511 institution engaged primarily in providing services for the prevention,
2512 diagnosis or treatment of human health conditions, including, but not
2513 limited to: Outpatient clinics; outpatient surgical facilities; imaging
2514 centers; home health agencies, critical access hospital as defined in
2515 section 19a-490, as amended by this act; clinical laboratory or central
2516 service facilities serving one or more health care facilities, practitioners
2517 or institutions; hospitals; nursing homes; rest homes; nonprofit health
2518 centers; diagnostic and treatment facilities; rehabilitation facilities; and
2519 mental health facilities. "Health care facility or institution" includes any
2520 parent company, subsidiary, affiliate or joint venture, or any
2521 combination thereof, of any such facility or institution, but does not
2522 include any health care facility operated by a nonprofit educational
2523 institution solely for the students, faculty and staff of such institution
2524 and their dependents, or any Christian Science sanatorium operated,
2525 or listed and certified, by the First Church of Christ, Scientist, Boston,
2526 Massachusetts.

2527 (2) "State health care facility or institution" means a hospital or other
2528 such facility or institution operated by the state providing services
2529 which are eligible for reimbursement under Title XVIII or XIX of the
2530 federal Social Security Act, 42 USC Section 301 et seq., as amended.

2531 (3) "Office" means the Office of Health Care Access.

2532 (4) "Commissioner" means the Commissioner of Health Care Access.

2533 (5) "Person" has the meaning assigned to it in section 4-166.

2534 Sec. 62. (NEW) (*Effective July 1, 2005*) There is established a critical
2535 access hospital account which shall be a separate, nonlapsing account
2536 within the General Fund. Moneys in the account shall be used by the

2537 Department of Social Services to fund the operations of the critical
2538 access hospital in the event of an activation. The account shall contain
2539 all moneys required by law to be deposited in the account.

2540 Sec. 63. (*Effective July 1, 2005*) (a) The sum of one dollar is
2541 appropriated to the Department of Social Services, from the General
2542 Fund, for the fiscal year ending June 30, 2006, for deposit in the
2543 account established pursuant to section 62 of this act.

2544 (b) The sum of one dollar is appropriated to the Department of
2545 Social Services, from the General Fund, for the fiscal year ending June
2546 30, 2007, for deposit in the account established pursuant to section 62
2547 of this act.

2548 Sec. 64. (NEW) (*Effective July 1, 2005*) Each individual health
2549 insurance policy providing coverage of the type specified in
2550 subdivisions (1) to (13), inclusive, of section 38a-469 of the general
2551 statutes, delivered, issued for delivery, renewed, amended or
2552 continued in the state on or after July 1, 2005, shall provide benefits for
2553 isolation care and emergency services provided by the state's critical
2554 access hospital. Such benefits shall be subject to any policy provisions
2555 which apply to other services covered by such policy. The rates paid
2556 by individual health insurance policies pursuant to this section shall be
2557 equal to the rates paid under the Medicaid program, as determined by
2558 the Department of Social Services.

2559 Sec. 65. (NEW) (*Effective July 1, 2005*) Each group health insurance
2560 policy providing coverage of the type specified in subdivisions (1) to
2561 (13), inclusive, of section 38a-469 of the general statutes, delivered,
2562 issued for delivery, renewed, amended or continued in the state on or
2563 after July 1, 2005, shall provide benefits for isolation care and
2564 emergency services provided by the state's critical access hospital.
2565 Such benefits shall be subject to any policy provisions which apply to
2566 other services covered by such policy. The rates paid by group health
2567 insurance policies pursuant to this section shall be equal to the rates
2568 paid under the Medicaid program, as determined by the Department

2569 of Social Services.

2570 Sec. 66. (NEW) (*Effective July 1, 2005*) The Commissioner of Social
2571 Services shall provide coverage for isolation care and emergency
2572 services provided by the state's critical access hospital to persons
2573 participating in the Husky Plan Part A and Part B and fee for services
2574 Medicaid programs under chapter 319v of the general statutes.

2575 Sec. 67 (NEW) (*Effective July 1, 2005*) The Commissioner of Public
2576 Health shall adopt regulations, in accordance with chapter 54 of the
2577 general statutes, to implement critical access hospital policies and
2578 procedures for isolation care and emergency services.

2579 Sec. 68. (*Effective from passage*) (a) The Commissioner of Public
2580 Health, in conjunction with the chairpersons of the joint standing
2581 committee of the General Assembly having cognizance of matters
2582 relating to public health, shall convene a working group to study
2583 whether the state should contract for the development of a program or
2584 enter into an existing program, that allows Connecticut residents to
2585 purchase prescription drugs through pharmacies located in Canada or
2586 other countries. The working group shall include, but not be limited to,
2587 the Commissioner of Public health, or the commissioner's designee, the
2588 chairpersons of the joint standing committee of the General Assembly
2589 having cognizance of matters relating to public health, or their
2590 designees, the Attorney General or the Attorney General's designee, a
2591 representative of the Office of Policy and Management and any other
2592 person the Commissioner of Public Health and the chairpersons of the
2593 joint standing committee of the General Assembly having cognizance
2594 of matters relating to public health deem necessary.

2595 (b) The study shall include (1) an evaluation of any new or existing
2596 prescription drug program that would allow Connecticut residents to
2597 purchase prescription drugs through pharmacies located in Canada or
2598 other countries (A) for the purpose of assessing whether the program
2599 would meet all of the current levels of safety and quality assurance
2600 afforded Connecticut residents with respect to the purchase of

2601 prescription drugs and whether the program would provide
2602 Connecticut residents who enroll in the program access to more
2603 affordable prescription drugs, and (B) to assess whether Connecticut
2604 residents would be required to compromise any legal rights as a
2605 condition of participating in the program, and (2) an examination of,
2606 and recommendations about, the parameters of a request for proposal
2607 to solicit the implementation of such prescription drug program in
2608 Connecticut.

2609 (c) The Commissioner of Public Health may enter into contracts
2610 with consultants to assist in the completion of the study authorized by
2611 this section.

2612 (d) Not later than January 1, 2006, the Commissioner of Public
2613 Health shall submit, in accordance with the provisions of section 11-4a
2614 of the general statutes, a report of the working group's findings and
2615 recommendations to the joint standing committees of the General
2616 Assembly having cognizance of matters relating to public health and
2617 appropriations and the budgets of state agencies.

2618 Sec. 69. (NEW) (*Effective October 1, 2005*) As used in sections 69 to 71,
2619 inclusive, of this act and subsection (c) of section 19a-14 of the general
2620 statutes, as amended by this act:

2621 (1) "Commissioner" means the Commissioner of Public Health.

2622 (2) "Department" means the Department of Public Health.

2623 (3) "Extracorporeal circulation" means the diversion of a patient's
2624 blood through a heart-lung machine or a similar device that assumes
2625 the functions of the patient's heart, lungs, kidney, liver or other organs.

2626 (4) "Perfusion" means the functions necessary for the support,
2627 treatment, measurement or supplementation of the cardiovascular,
2628 circulatory or respiratory system or other organs, or a combination of
2629 such activities, and to ensure the safe management of physiologic
2630 functions by monitoring and analyzing the parameters of the systems

2631 under an order and under the supervision of a licensed physician,
2632 including, but not limited to:

2633 (A) The use of extracorporeal circulation, long-term
2634 cardiopulmonary support techniques including extracorporeal carbon-
2635 dioxide removal and extracorporeal membrane oxygenation and
2636 associated therapeutic and diagnostic technologies;

2637 (B) Counterpulsation, ventricular assistance, autotransfusion, blood
2638 conservation techniques, myocardial and organ preservation,
2639 extracorporeal life support and isolated limb perfusion;

2640 (C) The use of techniques involving blood management, advanced
2641 life support and other related functions; and

2642 (D) In the performance of the following activities:

2643 (i) The administration of pharmacological and therapeutic agents, or
2644 blood products or anesthetic agents through the extracorporeal circuit
2645 or through an intravenous line as ordered by a physician;

2646 (ii) The performance and use of anticoagulation monitoring and
2647 analysis; physiologic monitoring and analysis; blood gas and
2648 chemistry monitoring and analysis; hematologic monitoring and
2649 analysis; hypothermia; hyperthermia; hemoconcentration and
2650 hemodilution; or modified extracorporeal circulatory hemodialysis; or

2651 (iii) The observation of signs and symptoms related to perfusion
2652 services, the determination of whether the signs and symptoms exhibit
2653 abnormal characteristics, and the implementation of appropriate
2654 reporting, perfusion protocols, or changes in or the initiation of
2655 emergency procedures.

2656 (5) "Perfusionist" means a person who is licensed to practice
2657 perfusion pursuant to the provisions of sections 48 to 50, inclusive, of
2658 this act.

2659 (6) "Direct supervision" means a supervising physician is physically

2660 present in the location where the perfusionist trainee is performing
2661 routine perfusion functions.

2662 Sec. 70. (NEW) (*Effective October 1, 2005*) (a) No person shall practice
2663 perfusion in this state unless the person holds a valid license from the
2664 department to practice perfusion in this state. No person shall use the
2665 title "perfusionist" or make use of any title, words, letters or
2666 abbreviations that may reasonably be confused with licensure as a
2667 perfusionist unless such person holds a valid license from the
2668 department to practice perfusion in this state.

2669 (b) Each person seeking licensure to practice perfusion in this state
2670 shall make application on forms prescribed by the department, pay an
2671 application fee of two hundred fifty dollars and present to the
2672 department satisfactory evidence that such person (1) successfully
2673 completed a perfusion education program with standards established
2674 by the Accreditation Committee for Perfusion Education and approved
2675 by the Commission on Accreditation of Allied Health Education
2676 Programs; (2) completed a minimum of fifty cases after graduating
2677 from a perfusion education program accredited or approved pursuant
2678 to subdivision (1) of this subsection; and (3) after completing the
2679 requirements set forth in subdivision (2) of this subsection,
2680 successfully completed the certification examination offered by the
2681 American Board of Cardiovascular Perfusion, or its successor. The
2682 commissioner shall grant a license as a perfusionist to any applicant
2683 who meets the requirements of this subsection.

2684 (c) From the period beginning October 1, 2005, and ending
2685 December 31, 2006, an applicant for licensure as a perfusionist may, in
2686 lieu of the requirements set forth in subsection (b) of this section,
2687 submit to the department satisfactory evidence that the applicant has
2688 (1) actively engaged in the practice of perfusion in this state since
2689 October 1, 2005, or earlier, and (2) been operating a cardiopulmonary
2690 bypass system during cardiac surgical procedures in a licensed health
2691 care facility as part of the applicant's primary job duties since October
2692 1, 2005. The commissioner shall grant a license as a perfusionist to any

2693 applicant who meets the requirements of this subsection.

2694 (d) Nothing in this section shall be construed to apply to the
2695 activities and services of a person who (1) has successfully completed a
2696 perfusion education program that meets the criteria of subdivision (1)
2697 of subsection (b) of this section from gaining experience in the practice
2698 of perfusion, provided such activities (A) are necessary to satisfy the
2699 requirements of subdivision (2) of said subsection (b), (B) are
2700 performed under direct supervision, and (C) such person is designated
2701 as an intern or trainee or other such title indicating the training status
2702 appropriate to such person's level of training, or (2) is enrolled in an
2703 accredited perfusion education program and performing such work as
2704 is incidental to the course of study.

2705 (e) The provisions of this section do not apply to any practicing
2706 physician or surgeon licensed under chapter 370 of the general
2707 statutes.

2708 (f) No license shall be issued under this section to any applicant
2709 against whom professional disciplinary action is pending or who is the
2710 subject of an unresolved complaint in this or any other state or
2711 territory.

2712 (g) Licenses shall be renewed annually in accordance with the
2713 provisions of section 19a-88 of the general statutes, as amended by this
2714 act, for a fee of two hundred fifty dollars.

2715 Sec. 71. (NEW) (*Effective October 1, 2005*) The Commissioner of
2716 Public Health may take any disciplinary action set forth in section 19a-
2717 17 of the general statutes, against a perfusionist for any of the
2718 following reasons: (1) Failure to conform to the accepted standards of
2719 the profession; (2) conviction of a felony; (3) fraud or deceit in
2720 obtaining or seeking reinstatement of a license to practice perfusion; (4)
2721 fraud or deceit in the practice of the profession; (5) negligent,
2722 incompetent or wrongful conduct in professional activities; (6)
2723 physical, mental or emotional illness or disorder resulting in an
2724 inability to conform to the accepted standards of the profession; (7)

2725 alcohol or substance abuse; (8) wilful falsification of entries in any
2726 hospital, patient or other record pertaining to the profession; or (9)
2727 violation of any provision of sections 69 to 71, inclusive, of this act. The
2728 commissioner may order a license holder to submit to a reasonable
2729 physical or mental examination if the physical or mental capacity of
2730 the license holder to practice safely is the subject of an investigation.
2731 The commissioner may petition the superior court for the judicial
2732 district of Hartford to enforce such order or any action taken pursuant
2733 to said section 19a-17. The commissioner shall give notice and an
2734 opportunity to be heard on any contemplated action under said section
2735 19a-17.

2736 Sec. 72. Subsection (c) of section 19a-14 of the general statutes, as
2737 amended by section 2 of public act 05-66, is repealed and the following
2738 is substituted in lieu thereof (*Effective October 1, 2005*):

2739 (c) No board shall exist for the following professions that are
2740 licensed or otherwise regulated by the Department of Public Health:

- 2741 (1) Speech pathologist and audiologist;
- 2742 (2) Hearing instrument specialist;
- 2743 (3) Nursing home administrator;
- 2744 (4) Sanitarian;
- 2745 (5) Subsurface sewage system installer or cleaner;
- 2746 (6) Marital and family therapist;
- 2747 (7) Nurse-midwife;
- 2748 (8) Licensed clinical social worker;
- 2749 (9) Respiratory care practitioner;
- 2750 (10) Asbestos contractor and asbestos consultant;

- 2751 (11) Massage therapist;
- 2752 (12) Registered nurse's aide;
- 2753 (13) Radiographer;
- 2754 (14) Dental hygienist;
- 2755 (15) Dietitian-Nutritionist;
- 2756 (16) Asbestos abatement worker;
- 2757 (17) Asbestos abatement site supervisor;
- 2758 (18) Licensed or certified alcohol and drug counselor;
- 2759 (19) Professional counselor;
- 2760 (20) Acupuncturist;
- 2761 (21) Occupational therapist and occupational therapist assistant;
- 2762 (22) Lead abatement contractor, lead consultant contractor, lead
2763 consultant, lead abatement supervisor, lead abatement worker,
2764 inspector and planner-project designer;
- 2765 (23) Emergency medical technician, emergency medical technician-
2766 intermediate, medical response technician and emergency medical
2767 services instructor;
- 2768 (24) Paramedic; [and]
- 2769 (25) Dialysis patient care technician; and
- 2770 (26) Perfusionist.
- 2771 The department shall assume all powers and duties normally vested
2772 with a board in administering regulatory jurisdiction over such
2773 professions. The uniform provisions of this chapter and chapters 368v,
2774 369 to 381a, inclusive, 383 to 388, inclusive, 393a, 395, 398, 399, 400a

2775 and 400c, including, but not limited to, standards for entry and
2776 renewal; grounds for professional discipline; receiving and processing
2777 complaints; and disciplinary sanctions, shall apply, except as otherwise
2778 provided by law, to the professions listed in this subsection.

2779 Sec. 73. Subsection (c) of section 19a-14 of the general statutes, as
2780 amended by section 8 of public act 00-226 and section 3 of public act
2781 05-66, is repealed and the following is substituted in lieu thereof
2782 (*Effective on and after the later of October 1, 2000, or the date notice is*
2783 *published by the Commissioner of Public Health in the Connecticut Law*
2784 *Journal indicating that the licensing of athletic trainers and physical therapist*
2785 *assistants is being implemented by the commissioner*):

2786 (c) No board shall exist for the following professions that are
2787 licensed or otherwise regulated by the Department of Public Health:

- 2788 (1) Speech pathologist and audiologist;
- 2789 (2) Hearing instrument specialist;
- 2790 (3) Nursing home administrator;
- 2791 (4) Sanitarian;
- 2792 (5) Subsurface sewage system installer or cleaner;
- 2793 (6) Marital and family therapist;
- 2794 (7) Nurse-midwife;
- 2795 (8) Licensed clinical social worker;
- 2796 (9) Respiratory care practitioner;
- 2797 (10) Asbestos contractor and asbestos consultant;
- 2798 (11) Massage therapist;
- 2799 (12) Registered nurse's aide;

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- 2800 (13) Radiographer;
- 2801 (14) Dental hygienist;
- 2802 (15) Dietitian-Nutritionist;
- 2803 (16) Asbestos abatement worker;
- 2804 (17) Asbestos abatement site supervisor;
- 2805 (18) Licensed or certified alcohol and drug counselor;
- 2806 (19) Professional counselor;
- 2807 (20) Acupuncturist;
- 2808 (21) Occupational therapist and occupational therapist assistant;
- 2809 (22) Lead abatement contractor, lead consultant contractor, lead
- 2810 consultant, lead abatement supervisor, lead abatement worker,
- 2811 inspector and planner-project designer;
- 2812 (23) Emergency medical technician, emergency medical technician-
- 2813 intermediate, medical response technician and emergency medical
- 2814 services instructor;
- 2815 (24) Paramedic;
- 2816 (25) Athletic trainer; [and]
- 2817 (26) Dialysis patient care technician; and
- 2818 (27) Perfusionist.

2819 The department shall assume all powers and duties normally vested

2820 with a board in administering regulatory jurisdiction over such

2821 professions. The uniform provisions of this chapter and chapters 368v,

2822 369 to 381a, inclusive, 383 to 388, inclusive, 393a, 395, 398, 399, 400a

2823 and 400c, including, but not limited to, standards for entry and

2824 renewal; grounds for professional discipline; receiving and processing

2825 complaints; and disciplinary sanctions, shall apply, except as otherwise
2826 provided by law, to the professions listed in this subsection.

2827 Sec. 74. Subsection (e) of section 19a-88 of the general statutes is
2828 amended by adding subdivision (5) as follows (*Effective October 1,*
2829 *2005*):

2830 (NEW) (5) Each person holding a license issued pursuant to section
2831 70 of this act shall, annually, during the month of such person's birth,
2832 apply for renewal of such license to the Department of Public Health,
2833 upon payment of a fee of two hundred fifty dollars, giving such
2834 person's name in full, such person's residence and business address
2835 and such other information as the department requests.

2836 Sec. 75. Subsection (e) of section 19a-88 of the general statutes, as
2837 amended by section 9 of public act 00-226, is amended by adding
2838 subdivision (5) as follows (*Effective on and after the later of October 1,*
2839 *2000, or the date notice is published by the Commissioner of Public Health in*
2840 *the Connecticut Law Journal indicating that the licensing of athletic trainers*
2841 *and physical therapist assistants is being implemented by the commissioner*):

2842 (NEW) (5) Each person holding a license issued pursuant to section
2843 70 of this act shall, annually, during the month of such person's birth,
2844 apply for renewal of such license to the Department of Public Health,
2845 upon payment of a fee of two hundred fifty dollars, giving such
2846 person's name in full, such person's residence and business address
2847 and such other information as the department requests.

2848 Sec. 76. Section 20-9 of the general statutes is repealed and the
2849 following is substituted in lieu thereof (*Effective October 1, 2005*):

2850 (a) No person shall, for compensation, gain or reward, received or
2851 expected, diagnose, treat, operate for or prescribe for any injury,
2852 deformity, ailment or disease, actual or imaginary, of another person,
2853 nor practice surgery, until he has obtained such a license as provided
2854 in section 20-10, and then only in the kind or branch of practice stated
2855 in such license.

- 2856 (b) The provisions of this chapter shall not apply to:
- 2857 (1) Dentists while practicing dentistry only;
- 2858 (2) Any person in the employ of the United States government while
2859 acting in the scope of his employment;
- 2860 (3) Any person who furnishes medical or surgical assistance in cases
2861 of sudden emergency;
- 2862 (4) Any person residing out of this state who is employed to come
2863 into this state to render temporary assistance to or consult with any
2864 physician or surgeon who has been licensed in conformity with the
2865 provisions of this chapter;
- 2866 (5) Any physician or surgeon residing out of this state who holds a
2867 current license in good standing in another state and who is employed
2868 to come into this state to treat, operate or prescribe for any injury,
2869 deformity, ailment or disease from which the person who employed
2870 such physician, or the person on behalf of whom such physician is
2871 employed, is suffering at the time when such nonresident physician or
2872 surgeon is so employed, provided such physician or surgeon may
2873 practice in this state without a Connecticut license for a period not to
2874 exceed thirty consecutive days;
- 2875 (6) Any person rendering service as (A) an advanced practice
2876 registered nurse if such service is rendered in collaboration with a
2877 licensed physician, or (B) an advanced practice registered nurse
2878 maintaining classification from the American Association of Nurse
2879 Anesthetists if such service is under the direction of a licensed
2880 physician;
- 2881 (7) Any nurse-midwife practicing nurse-midwifery in accordance
2882 with the provisions of chapter 377;
- 2883 (8) Any podiatrist licensed in accordance with the provisions of
2884 chapter 375;

2885 (9) Any Christian Science practitioner who does not use or prescribe
2886 in his practice any drugs, poisons, medicines, chemicals, nostrums or
2887 surgery;

2888 (10) Any person licensed to practice any of the healing arts named
2889 in section 20-1, who does not use or prescribe in his practice any drugs,
2890 medicines, poisons, chemicals, nostrums or surgery;

2891 (11) Any graduate of any school or institution giving instruction in
2892 the healing arts who has been issued a permit in accordance with
2893 subsection (a) of section 20-11a and who is serving as an intern,
2894 resident or medical officer candidate in a hospital;

2895 (12) Any student participating in a clinical clerkship program who
2896 has the qualifications specified in subsection (b) of section 20-11a;

2897 (13) Any person, otherwise qualified to practice medicine in this
2898 state except that he is a graduate of a medical school located outside of
2899 the United States or the Dominion of Canada which school is
2900 recognized by the American Medical Association or the World Health
2901 Organization, to whom the Connecticut Medical Examining Board,
2902 subject to such regulations as the Commissioner of Public Health, with
2903 advice and assistance from the board, prescribes, has issued a permit
2904 to serve as an intern or resident in a hospital in this state for the
2905 purpose of extending his education;

2906 (14) Any person rendering service as a physician assistant licensed
2907 pursuant to section 20-12b, a registered nurse, a licensed practical
2908 nurse or a paramedic, as defined in subdivision (15) of section 19a-175,
2909 acting within the scope of regulations adopted pursuant to section 19a-
2910 179, if such service is rendered under the supervision, control and
2911 responsibility of a licensed physician;

2912 (15) Any student enrolled in an accredited physician assistant
2913 program or paramedic program approved in accordance with
2914 regulations adopted pursuant to section 19a-179, who is performing
2915 such work as is incidental to his course of study;

2916 (16) Any person who, on June 1, 1993, has worked continuously in
2917 this state since 1979 performing diagnostic radiology services and who,
2918 as of October 31, 1997, continued to render such services under the
2919 supervision, control and responsibility of a licensed physician solely
2920 within the setting where such person was employed on June 1, 1993;

2921 (17) Any person performing athletic training as described in section
2922 19a-16a;

2923 (18) When deemed by the Connecticut Medical Examining Board to
2924 be in the public's interest, based on such considerations as academic
2925 attainments, specialty board certification and years of experience, to a
2926 foreign physician or surgeon whose professional activities shall be
2927 confined within the confines of a recognized medical school; [or]

2928 (19) Any technician engaging in tattooing in accordance with the
2929 provisions of section 19a-92a and any regulations adopted thereunder;
2930 or

2931 (20) Any person practicing perfusion, as defined in section 69 of this
2932 act.

2933 (c) This section shall not authorize anyone to practice optometry, as
2934 defined in chapter 380, or to practice dentistry, as defined in chapter
2935 379, or dental hygiene, as defined in chapter 379a.

2936 (d) The provisions of subsection (a) of this section shall apply to any
2937 individual whose practice of medicine includes any ongoing, regular
2938 or contractual arrangement whereby, regardless of residency in this or
2939 any other state, he provides, through electronic communications or
2940 interstate commerce, diagnostic or treatment services, including
2941 primary diagnosis of pathology specimens, slides or images, to any
2942 person located in this state. In the case of electronic transmissions of
2943 radiographic images, licensure shall be required for an out-of-state
2944 physician who provides, through an ongoing, regular or contractual
2945 arrangement, official written reports of diagnostic evaluations of such
2946 images to physicians or patients in this state. The provisions of

2947 subsection (a) of this section shall not apply to a nonresident physician
2948 who, while located outside this state, consults (A) on an irregular basis
2949 with a physician licensed by section 20-10 who is located in this state
2950 or (B) with a medical school within this state for educational or
2951 medical training purposes. Notwithstanding the provisions of this
2952 subsection, the provisions of subsection (a) of this section shall not
2953 apply to any individual who regularly provides the types of services
2954 described in this subsection pursuant to any agreement or
2955 arrangement with a short-term acute care general hospital, licensed by
2956 the Department of Public Health, provided such agreement or
2957 arrangement was entered into prior to February 1, 1996, and is in effect
2958 as of October 1, 1996.

2959 (e) On and after October 1, 1999, any person licensed as an
2960 osteopathic physician or osteopath pursuant to chapter 371 shall be
2961 deemed licensed as a physician and surgeon pursuant to this chapter.

2962 Sec. 77. Section 20-9 of the general statutes is repealed and the
2963 following is substituted in lieu thereof (*Effective On and after the later of*
2964 *October 1, 2000, or the date notice is published by the Commissioner of Public*
2965 *Health in the Connecticut Law Journal indicating that the licensing of athletic*
2966 *trainers and physical therapist assistants is being implemented by the*
2967 *commissioner*):

2968 (a) No person shall, for compensation, gain or reward, received or
2969 expected, diagnose, treat, operate for or prescribe for any injury,
2970 deformity, ailment or disease, actual or imaginary, of another person,
2971 nor practice surgery, until he has obtained such a license as provided
2972 in section 20-10, and then only in the kind or branch of practice stated
2973 in such license.

2974 (b) The provisions of this chapter shall not apply to:

2975 (1) Dentists while practicing dentistry only;

2976 (2) Any person in the employ of the United States government while
2977 acting in the scope of his employment;

2978 (3) Any person who furnishes medical or surgical assistance in cases
2979 of sudden emergency;

2980 (4) Any person residing out of this state who is employed to come
2981 into this state to render temporary assistance to or consult with any
2982 physician or surgeon who has been licensed in conformity with the
2983 provisions of this chapter;

2984 (5) Any physician or surgeon residing out of this state who holds a
2985 current license in good standing in another state and who is employed
2986 to come into this state to treat, operate or prescribe for any injury,
2987 deformity, ailment or disease from which the person who employed
2988 such physician, or the person on behalf of whom such physician is
2989 employed, is suffering at the time when such nonresident physician or
2990 surgeon is so employed, provided such physician or surgeon may
2991 practice in this state without a Connecticut license for a period not to
2992 exceed thirty consecutive days;

2993 (6) Any person rendering service as (A) an advanced practice
2994 registered nurse if such service is rendered in collaboration with a
2995 licensed physician, or (B) an advanced practice registered nurse
2996 maintaining classification from the American Association of Nurse
2997 Anesthetists if such service is under the direction of a licensed
2998 physician;

2999 (7) Any nurse-midwife practicing nurse-midwifery in accordance
3000 with the provisions of chapter 377;

3001 (8) Any podiatrist licensed in accordance with the provisions of
3002 chapter 375;

3003 (9) Any Christian Science practitioner who does not use or prescribe
3004 in his practice any drugs, poisons, medicines, chemicals, nostrums or
3005 surgery;

3006 (10) Any person licensed to practice any of the healing arts named
3007 in section 20-1, who does not use or prescribe in his practice any drugs,

3008 medicines, poisons, chemicals, nostrums or surgery;

3009 (11) Any graduate of any school or institution giving instruction in
3010 the healing arts who has been issued a permit in accordance with
3011 subsection (a) of section 20-11a and who is serving as an intern,
3012 resident or medical officer candidate in a hospital;

3013 (12) Any student participating in a clinical clerkship program who
3014 has the qualifications specified in subsection (b) of section 20-11a;

3015 (13) Any person, otherwise qualified to practice medicine in this
3016 state except that he is a graduate of a medical school located outside of
3017 the United States or the Dominion of Canada which school is
3018 recognized by the American Medical Association or the World Health
3019 Organization, to whom the Connecticut Medical Examining Board,
3020 subject to such regulations as the Commissioner of Public Health, with
3021 advice and assistance from the board, prescribes, has issued a permit
3022 to serve as an intern or resident in a hospital in this state for the
3023 purpose of extending his education;

3024 (14) Any person rendering service as a physician assistant licensed
3025 pursuant to section 20-12b, a registered nurse, a licensed practical
3026 nurse or a paramedic, as defined in subdivision (15) of section 19a-175,
3027 acting within the scope of regulations adopted pursuant to section 19a-
3028 179, if such service is rendered under the supervision, control and
3029 responsibility of a licensed physician;

3030 (15) Any student enrolled in an accredited physician assistant
3031 program or paramedic program approved in accordance with
3032 regulations adopted pursuant to section 19a-179, who is performing
3033 such work as is incidental to his course of study;

3034 (16) Any person who, on June 1, 1993, has worked continuously in
3035 this state since 1979 performing diagnostic radiology services and who,
3036 as of October 31, 1997, continued to render such services under the
3037 supervision, control and responsibility of a licensed physician solely
3038 within the setting where such person was employed on June 1, 1993;

3039 (17) Any person practicing athletic training, as defined in section 20-
3040 65f;

3041 (18) When deemed by the Connecticut Medical Examining Board to
3042 be in the public's interest, based on such considerations as academic
3043 attainments, specialty board certification and years of experience, to a
3044 foreign physician or surgeon whose professional activities shall be
3045 confined within the confines of a recognized medical school; [or]

3046 (19) Any technician engaging in tattooing in accordance with the
3047 provisions of section 19a-92a and any regulations adopted thereunder;
3048 or

3049 (20) Any person practicing perfusion, as defined in section 69 of this
3050 act.

3051 (c) This section shall not authorize anyone to practice optometry, as
3052 defined in chapter 380, or to practice dentistry, as defined in chapter
3053 379, or dental hygiene, as defined in chapter 379a.

3054 (d) The provisions of subsection (a) of this section shall apply to any
3055 individual whose practice of medicine includes any ongoing, regular
3056 or contractual arrangement whereby, regardless of residency in this or
3057 any other state, he provides, through electronic communications or
3058 interstate commerce, diagnostic or treatment services, including
3059 primary diagnosis of pathology specimens, slides or images, to any
3060 person located in this state. In the case of electronic transmissions of
3061 radiographic images, licensure shall be required for an out-of-state
3062 physician who provides, through an ongoing, regular or contractual
3063 arrangement, official written reports of diagnostic evaluations of such
3064 images to physicians or patients in this state. The provisions of
3065 subsection (a) of this section shall not apply to a nonresident physician
3066 who, while located outside this state, consults (A) on an irregular basis
3067 with a physician licensed by section 20-10 who is located in this state
3068 or (B) with a medical school within this state for educational or
3069 medical training purposes. Notwithstanding the provisions of this
3070 subsection, the provisions of subsection (a) of this section shall not

3071 apply to any individual who regularly provides the types of services
3072 described in this subsection pursuant to any agreement or
3073 arrangement with a short-term acute care general hospital, licensed by
3074 the Department of Public Health, provided such agreement or
3075 arrangement was entered into prior to February 1, 1996, and is in effect
3076 as of October 1, 1996.

3077 (e) On and after October 1, 1999, any person licensed as an
3078 osteopathic physician or osteopath pursuant to chapter 371 shall be
3079 deemed licensed as a physician and surgeon pursuant to this chapter.

3080 Sec. 78. Subsection (b) of section 17a-450 of the general statutes is
3081 repealed and the following is substituted in lieu thereof (*Effective July*
3082 *1, 2005*):

3083 (b) For the purposes of chapter 50, the Department of Mental Health
3084 and Addiction Services [shall be a single budgeted agency. It shall
3085 consist of two divisions, the Division of Mental Health Services and the
3086 Division of Substance Abuse Services, that] shall be organized to
3087 promote comprehensive, client-based services in the areas of mental
3088 health treatment and substance abuse treatment and to ensure the
3089 programmatic integrity and clinical identity of services in each area.
3090 The department shall perform the functions of: Centralized
3091 administration, planning and program development; prevention and
3092 treatment programs and facilities, both inpatient and outpatient, for
3093 persons with psychiatric disabilities or persons with substance abuse
3094 disabilities, or both; community mental health centers and community
3095 or regional programs and facilities providing services for persons with
3096 psychiatric disabilities or persons with substance abuse disabilities, or
3097 both; training and education; and research and evaluation of programs
3098 and facilities providing services for persons with psychiatric
3099 disabilities or persons with substance abuse disabilities, or both. The
3100 department shall include, but not be limited to, the following divisions
3101 and facilities or their successor facilities: The office of the
3102 Commissioner of Mental Health and Addiction Services; Capitol
3103 Region Mental Health Center; Connecticut Valley Hospital, including

3104 the Acute Care Division of Connecticut Valley Hospital; the
3105 Connecticut Mental Health Center; the Whiting Forensic Division;
3106 Ribicoff Research Center; [Cedarcrest Hospital;] the Southwest
3107 Connecticut Mental Health System, including the Franklin S. DuBois
3108 Center and the Greater Bridgeport Community Mental Health Center;
3109 the Southeastern Mental Health Authority; River Valley Services; the
3110 Western Connecticut Mental Health Network; and any other
3111 state-operated facility for the treatment of persons with psychiatric
3112 disabilities or persons with substance abuse disabilities, or both, but
3113 shall not include those portions of such facilities transferred to the
3114 Department of Children and Families for the purpose of consolidation
3115 of children's services.

3116 Sec. 79. Subsection (c) of section 17a-458 of the general statutes is
3117 repealed and the following is substituted in lieu thereof (*Effective July*
3118 *1, 2005*):

3119 (c) "State-operated facilities" means those hospitals or other facilities
3120 providing treatment for persons with psychiatric disabilities or for
3121 persons with substance abuse disabilities, or both, which are operated
3122 in whole or in part by the Department of Mental Health and Addiction
3123 Services. Such facilities include, but are not limited to, Capitol Region
3124 Mental Health Center, Connecticut Valley Hospital, including the
3125 Acute Care Division of Connecticut Valley Hospital, Norwich
3126 Hospital, Fairfield Hills Hospital, the Connecticut Mental Health
3127 Center, the Franklin S. DuBois Center, [Cedarcrest Regional Hospital,]
3128 the Greater Bridgeport Community Mental Health Center [, Blue Hills
3129 Hospital, Berkshire Woods Treatment Center, Eugene Boneski
3130 Treatment Center,] and Dutcher Treatment Center. [, but shall not
3131 include those portions of such facilities transferred to the Department
3132 of Children and Families for the purpose of consolidation of children's
3133 services.]

3134 Sec. 80. (NEW) (*Effective July 1, 2005*) If the term "Acute Care
3135 Division" is used or referred to in any public or special act of 2005 or
3136 2006 or in any section of the general statutes that is amended in 2005 or

3137 2006, it shall be deemed to mean or refer to the Acute Care Division of
3138 Connecticut Valley Hospital.

3139 Sec. 81. (NEW) (*Effective July 1, 2005*) Regardless of any
3140 consolidation of operational functions at Connecticut Valley Hospital
3141 and Cedarcrest Hospital, the campuses of Connecticut Valley Hospital
3142 and Cedarcrest Hospital shall constitute separate hospitals for
3143 purposes of section 17a-511 of the general statutes, and each such
3144 hospital shall designate an administrator who is authorized to render
3145 final decisions resolving patient complaints and grievances.

3146 Sec. 82. Section 19a-405 of the general statutes is repealed and the
3147 following is substituted in lieu thereof (*Effective July 1, 2005*):

3148 The Chief Medical Examiner, with the approval of the commission,
3149 shall appoint a deputy who shall perform all the duties of the Chief
3150 Medical Examiner in case of his sickness or absence and such associate
3151 medical examiners, assistant medical examiners, pathologists,
3152 toxicologists, laboratory technicians and other professional staff as the
3153 commission may specify. The commission in advance of appointments
3154 shall specify the qualifications required for each position in terms of
3155 education, experience and other relevant considerations. The
3156 commission shall fix the annual salary of the Deputy Chief Medical
3157 Examiner and shall submit recommendations concerning salaries and
3158 compensation of [such] other professional staff to the Commissioner of
3159 Administrative Services. The Chief Medical Examiner, the Deputy
3160 Chief Medical Examiner, associate medical examiners, and assistant
3161 medical examiners shall take the oath provided by law for public
3162 officers. Other staff members as determined by the commission shall
3163 be appointed by the Chief Medical Examiner, subject to the provisions
3164 of chapter 67 and the rules of the commission not inconsistent
3165 therewith.

3166 Sec. 83. (NEW) (*Effective July 1, 2005*) On or before July 1, 2006, the
3167 Commissioner of Mental Health and Addiction Services shall initiate
3168 the development, implementation, promotion and maintenance of a

3169 single resource web site to provide timely access to mental health care
3170 information and assistance for children, adolescents and adults. The
3171 resource web site shall include, but not be limited to: (1) Directory
3172 information on available federal, state, regional and community
3173 assistance, programs, services and providers; (2) current mental health
3174 diagnoses and treatment options; (3) links to national and state
3175 advocacy organizations, including legal assistance; (4) summary
3176 information on federal and state mental health law, including private
3177 insurance coverage; and (5) an optional, secure personal folder for web
3178 site users to manage information concerning their individual mental
3179 health care and assistance.

3180 Sec. 84. (NEW) (*Effective from passage*) (a) On or before December 31,
3181 2006, the Commissioner of Social Services, in consultation with the
3182 Commissioner of Mental Health and Addiction Services and the
3183 Community Mental Health Strategy Board, established under section
3184 17a-485b of the general statutes, shall take such action as is necessary
3185 to amend the Medicaid state plan to include assertive community
3186 treatment teams and community support services within the definition
3187 of optional adult rehabilitation services. Such community treatment
3188 teams shall provide intensive, integrated, multidisciplinary services to
3189 adults with severe psychiatric disabilities, including, but not limited to,
3190 persons who are homeless, persons diverted or discharged from in-
3191 patient programs or nursing homes and persons diverted or released
3192 from correctional facilities, or who are at risk of incarceration, and such
3193 teams shall provide intensive community care management through
3194 case managers, nurses and physicians and shall include, but not be
3195 limited to, vocational, peer and substance abuse specialists. The
3196 Commissioner of Social Services shall adopt regulations, in accordance
3197 with the provisions of chapter 54 of the general statutes, for purposes
3198 of establishing the services specified in this subsection. The
3199 Commissioner of Social Services may implement policies and
3200 procedures for purposes of establishing such services while in the
3201 process of adopting such policies or procedures in regulation form,
3202 provided notice of intention to adopt the regulations is printed in the

3203 Connecticut Law Journal no later than twenty days after
3204 implementation and any such policies and procedures shall be valid
3205 until the time the regulations are effective.

3206 (b) For purposes of this section, the Commissioner of Social Services
3207 shall enter into a memorandum of understanding with the Department
3208 of Mental Health and Addiction Services that delegates responsibility
3209 to the Commissioner of Mental Health and Addiction Services for the
3210 clinical management of adult rehabilitation services provided to adults
3211 eighteen years of age or older who are otherwise receiving mental
3212 health services from said department. For purposes of this section, the
3213 term "clinical management" describes the process of evaluating and
3214 determining the appropriateness of the utilization of behavioral health
3215 services, providing assistance to clinicians or beneficiaries to ensure
3216 appropriate use of resources and may include, but is not limited to,
3217 authorization, concurrent and retrospective review, discharge review,
3218 quality management, provider certification and provider performance
3219 enhancement. The Commissioner of Social Services and the
3220 Commissioner of Mental Health and Addiction Services shall jointly
3221 develop clinical management policies and procedures for purposes of
3222 this section. The Commissioner of Social Services may implement
3223 policies and procedures necessary to carry out the purposes of this
3224 section, including any necessary changes to existing behavioral health
3225 policies and procedures concerning utilization management, while in
3226 the process of adopting such policies and procedures in regulation
3227 form, in accordance with the provisions of chapter 54 of the general
3228 statutes, provided the commissioner publishes notice of intention to
3229 adopt the regulations in the Connecticut Law Journal not later than
3230 twenty days after implementing such policies and procedures. Policies
3231 and procedures implemented pursuant to this subsection shall be valid
3232 until the earlier of the time such regulations are effective, or December
3233 1, 2006.

3234 Sec. 85. (NEW) (*Effective from passage*) On or before July 1, 2005, the
3235 Commissioner of Social Services and the Commissioner of Mental
3236 Health and Addiction Services shall jointly convene a task force to

3237 develop and report to the Governor and General Assembly on or
3238 before January 1, 2006, in accordance with the provisions of section 11-
3239 4a of the general statutes, on a feasibility plan to obtain a waiver from
3240 federal law and establish a Medicaid-financed home and community-
3241 based pilot program to provide community-based services and, if
3242 necessary, housing assistance, to adults with severe and persistent
3243 psychiatric disabilities being discharged or diverted from nursing
3244 home residential care. The task force shall consist of (1) the
3245 Commissioner of Social Services, or a designee; (2) the Commissioner
3246 of Mental Health and Addiction Services, or a designee; (3) the
3247 Secretary of the Office of Policy and Management, or a designee; (4)
3248 the cochairs and ranking members of the joint standing committees of
3249 the General Assembly having cognizance of matters relating to public
3250 health and human services; and (5) three members designated by the
3251 Community Mental Health Strategy Board, established under section
3252 17a-485b of the general statutes.

3253 Sec. 86. (NEW) (*Effective from passage*) On or before January 1, 2006,
3254 the Commissioner of Mental Health and Addiction Services shall,
3255 within available appropriations, expand young adult services to cover
3256 additional catchment areas in the state and shall identify additional
3257 services not being provided to young adults with psychiatric
3258 disabilities. On or before January 1, 2007, the Commissioner of Mental
3259 Health and Addiction Services shall report, in accordance with the
3260 provisions of section 11-4a of the general statutes, on the need for such
3261 expanded services and identify additional services needed to the joint
3262 standing committees of the General Assembly having cognizance of
3263 matters relating to public health and human services.

3264 Sec. 87. (*Effective July 1, 2005*) The Commissioner of Children and
3265 Families, in consultation with the Commissioner of Mental Health and
3266 Addiction Services and the Community Mental Health Strategy Board,
3267 established under section 17a-485b of the general statutes, shall, within
3268 available appropriations, maintain the availability of flexible
3269 emergency funding for children with psychiatric disabilities who are
3270 not under the supervision of the Department of Children and Families.

3271 Sec. 88. (NEW) (*Effective July 1, 2005*) The Commissioner of Mental
3272 Health and Addiction Services shall, within available appropriations,
3273 provide additional supported or supervised housing for adults with
3274 severe and persistent psychiatric disabilities.

3275 Sec. 89. Section 38a-1041 of the general statutes is amended by
3276 adding subsection (e) as follows (*Effective from passage*):

3277 (NEW) (e) On or before October 1, 2005, the Managed Care
3278 Ombudsman, in consultation with the Community Mental Health
3279 Strategy Board, established under section 17a-485b of the general
3280 statutes, shall establish a process to provide ongoing communication
3281 among mental health care providers, patients, state-wide and regional
3282 business organizations, managed care companies and other health
3283 insurers to assure: (1) Best practices in mental health treatment and
3284 recovery; (2) compliance with the provisions of sections 38a-476a, 38a-
3285 476b, 38a-488a and 38a-489 of the general statutes; and (3) the relative
3286 costs and benefits of providing effective mental health care coverage to
3287 employees and their families. On or before January 1, 2006, and
3288 annually thereafter, the Managed Care Ombudsman shall report, in
3289 accordance with the provisions of section 11-4a of the general statutes,
3290 on the implementation of this subsection to the joint standing
3291 committees of the General Assembly having cognizance of matters
3292 relating to public health and insurance.

3293 Sec. 90. (*Effective from passage*) The Commissioner of Social Services,
3294 in consultation with the Commissioner of Mental Health and
3295 Addiction Services and the Secretary of the Office of Policy and
3296 Management, shall determine and report to the Governor and the
3297 General Assembly on or before January 1, 2006, in accordance with the
3298 provisions of section 11-4a of the general statutes, the feasibility of
3299 implementing enhanced care clinics for adults, including hospital-
3300 based clinics, and establishing a schedule of Medicaid reimbursement
3301 for such clinics on or before July 1, 2006.

3302 Sec. 91. (*Effective from passage*) (a) The Commissioner of the Office of

3303 Health Care Access shall establish a committee to examine whether
3304 licensed hospital psychiatric inpatient bed capacity for children in this
3305 state is sufficient and what steps, if any, are necessary to expand such
3306 capacity. The committee shall make specific recommendations
3307 concerning the expansion of licensed hospital psychiatric inpatient bed
3308 capacity for children in mental health region five, established pursuant
3309 to section 17a-478 of the general statutes.

3310 (b) The committee shall consist of the following members:

3311 (1) The Commissioners of Social Services and Children and
3312 Families, or the commissioners' designees;

3313 (2) The state Child Advocate, or the Child Advocate's designee; and

3314 (3) Representatives of private children's hospitals and mental health
3315 advocacy groups for children.

3316 (c) Not later than January 1, 2006, the Commissioner of the Office of
3317 Health Care Access shall submit a report, in accordance with the
3318 provisions of section 11-4a of the general statutes, on the committee's
3319 findings and recommendations to the General Assembly.

3320 Sec. 92. (NEW) (*Effective July 1, 2005*) (a) The Commissioners of
3321 Social Services and Children and Families shall develop and
3322 implement an integrated behavioral health service system for HUSKY
3323 Part A and HUSKY Part B members, children enrolled in the voluntary
3324 services program operated by the Department of Children and
3325 Families and may, at the discretion of the Commissioners of Children
3326 and Families and Social Services, include other children, adolescents
3327 and families served by the Department of Children and Families,
3328 which shall be known as the Behavioral Health Partnership. The
3329 Behavioral Health Partnership shall seek to increase access to quality
3330 behavioral health services through: (1) Expansion of individualized,
3331 family-centered, community-based services; (2) maximization of
3332 federal revenue to fund behavioral health services; (3) reduction in the
3333 unnecessary use of institutional and residential services for children;

3334 (4) capture and investment of enhanced federal revenue and savings
3335 derived from reduced residential services and increased community-
3336 based services; (5) improved administrative oversight and efficiencies;
3337 and (6) monitoring of individual outcomes, provider performance,
3338 taking into consideration the acuity of the patients served by each
3339 provider, and overall program performance.

3340 (b) The Behavioral Health Partnership shall operate in accordance
3341 with the financial requirements specified in this subsection. Prior to the
3342 conversion of any grant funded services to a rate-based, fee-for-service
3343 payment system, the Department of Social Services and the
3344 Department of Children and Families shall submit documentation
3345 verifying that the proposed rates seek to cover the reasonable cost of
3346 providing services to the Behavioral Health Partnership Oversight
3347 Council, established pursuant to section 95 of this act.

3348 Sec. 93. (NEW) (*Effective July 1, 2005*) (a) The Commissioner of
3349 Children and Families and the Commissioner of Social Services shall
3350 each designate a director for the Behavioral Health Partnership. Each
3351 director shall coordinate the responsibilities of his or her department,
3352 within the statutory authority of each department, for the planning,
3353 development, administration and evaluation of the activities specified
3354 under subsection (a) of section 92 of this act to increase access to
3355 quality behavioral health services.

3356 (b) The departments shall direct the activities of the administrative
3357 services organization, retained in accordance with section 17a-22f of
3358 the general statutes, as amended by this act, under terms established in
3359 a memorandum of understanding, in the development of a community
3360 system of care to:

3361 (1) Alleviate hospital emergency department overcrowding;

3362 (2) Reduce unnecessary admissions and lengths of stay in hospitals
3363 and residential treatment settings; and

3364 (3) Increase availability of outpatient services.

3365 Sec. 94. Section 17a-22f of the general statutes is repealed and the
3366 following is substituted in lieu thereof (*Effective from passage*):

3367 (a) The Commissioner of Social Services may, with regard to the
3368 provision of behavioral health services provided pursuant to a state
3369 plan under Title XIX or Title XXI of the Social Security Act: (1) Contract
3370 with an administrative services organization to provide clinical
3371 management, provider network development and other administrative
3372 services; and (2) delegate responsibility to the Department of Children
3373 and Families for the clinical management portion of [an] such
3374 administrative contract. [pertaining to children under eighteen years of
3375 age or individuals who are otherwise receiving behavioral health
3376 services from said department.]

3377 (b) For purposes of this section, the term "clinical management"
3378 describes the process of evaluating and determining the
3379 appropriateness of the utilization of behavioral health services,
3380 providing assistance to clinicians or beneficiaries to ensure appropriate
3381 use of resources and may include, but is not limited to, authorization,
3382 concurrent and retrospective review, discharge review, quality
3383 management, provider certification and provider performance
3384 enhancement. The Commissioners of Social Services and Children and
3385 Families shall jointly develop clinical management policies and
3386 procedures. The Department of Social Services may implement policies
3387 and procedures necessary to carry out the purposes of this section,
3388 including any necessary changes to existing behavioral health policies
3389 and procedures concerning utilization management, while in the
3390 process of adopting such policies and procedures in regulation form,
3391 provided the commissioner publishes notice of intention to adopt the
3392 regulations in the Connecticut Law Journal within twenty days of
3393 implementing such policies and procedures. Policies and procedures
3394 implemented pursuant to this subsection shall be valid until the earlier
3395 of (1) the time such regulations are effective, or (2) [December 1, 2003]
3396 December 31, 2006.

3397 Sec. 95. (NEW) (*Effective from passage*) (a) There is established a

3398 Behavioral Health Partnership Oversight Council which shall advise
3399 the Commissioners of Children and Families and Social Services on the
3400 planning and implementation of the Behavioral Health Partnership.

3401 (b) The council shall consist of the following members:

3402 (1) The chairpersons and ranking members of the joint standing
3403 committees of the General Assembly having cognizance of matters
3404 relating to human services, public health, appropriations and budgets
3405 of state agencies, or their designees;

3406 (2) A member of the Community Mental Health Strategy Board,
3407 established pursuant to section 17a-485b of the general statutes, as
3408 selected by said board;

3409 (3) The Commissioner of Mental Health and Addiction Services, or
3410 said commissioner's designee;

3411 (4) Sixteen members appointed by the chairpersons of the advisory
3412 council on Medicaid managed care, established pursuant to section
3413 17b-28 of the general statutes;

3414 (A) Two of whom are representatives of general or specialty
3415 psychiatric hospitals;

3416 (B) One of whom is an adult with a psychiatric disability;

3417 (C) One of whom is an advocate for adults with psychiatric
3418 disabilities;

3419 (D) Two of whom are parents of children who have a behavioral
3420 health disorder or have received child protection or juvenile justice
3421 services from the Department of Children and Families;

3422 (E) One of whom has expertise in health policy and evaluation;

3423 (F) One of whom is an advocate for children with behavioral health
3424 disorders;

3425 (G) One of whom is a primary care provider serving HUSKY
3426 children;

3427 (H) One of whom is a child psychiatrist serving HUSKY children;

3428 (I) One of whom is either an adult with a substance use disorder or
3429 an advocate for adults with substance use disorders;

3430 (J) One of whom is a representative of school-based health clinics;

3431 (K) One of whom is a provider of community-based behavioral
3432 health services for adults;

3433 (L) One of whom is a provider of residential treatment for children;

3434 (M) One of whom is a provider of community-based services for
3435 children with behavioral health problems; and

3436 (N) One of whom is a member of the advisory council on Medicaid
3437 managed care;

3438 (5) Four nonvoting ex-officio members, one each appointed by the
3439 Commissioners of Social Services, Children and Families and Mental
3440 Health and Addiction Services to represent his or her department and
3441 one appointed by the Secretary of the Office of Policy and
3442 Management to represent said department; and

3443 (6) One representative from the administrative services organization
3444 and from each Medicaid managed care organization, to be nonvoting
3445 ex-officio members.

3446 (c) All appointments to the council shall be made no later than July
3447 1, 2005. Any vacancy shall be filled by the appointing authority.

3448 (d) The chairpersons of the advisory council on Medicaid managed
3449 care shall select the chairpersons of the Behavioral Health Partnership
3450 Oversight Council from among the members of such oversight council.
3451 Such chairpersons shall convene the first meeting of the council, which
3452 shall be held not later than August 1, 2005. The council shall meet at

3453 least monthly thereafter.

3454 (e) The Joint Committee on Legislative Management shall provide
3455 administrative support to the chairpersons and assistance in convening
3456 the council's meetings.

3457 (f) The council shall make specific recommendations on matters
3458 related to the planning and implementation of the Behavioral Health
3459 Partnership which shall include, but not be limited to: (1) Review of
3460 any contract entered into by the Departments of Children and Families
3461 and Social Services with an administrative services organization, to
3462 assure that the administrative services organization's decisions are
3463 based solely on clinical management criteria developed by the clinical
3464 management committee established in section 96 of this act; (2) review
3465 of behavioral health services pursuant to Title XIX and Title XXI of the
3466 Social Security Act to assure that federal revenue is being maximized;
3467 and (3) review of periodic reports on the program activities, finances
3468 and outcomes, including reports from the director of the Behavioral
3469 Health Partnership on achievement of service delivery system goals,
3470 pursuant to section 93 of this act. The council may conduct or cause to
3471 be conducted an external, independent evaluation of the Behavioral
3472 Health Partnership.

3473 (g) On or before March 1, 2006, and annually thereafter, the council
3474 shall submit a report to the Governor and, in accordance with section
3475 11-4a of the general statutes, to the joint standing committees of the
3476 General Assembly having cognizance of matters relating to human
3477 services, public health and appropriations and budgets of state
3478 agencies, on the council's activities and progress.

3479 Sec. 96. (NEW) (*Effective July 1, 2005*) There is established a clinical
3480 management committee to develop clinical management guidelines to
3481 be used for the Behavioral Health Partnership. The committee shall
3482 consist of two members selected by the Commissioner of Children and
3483 Families, two members selected by the Commissioner of Social
3484 Services, one member selected by the Commissioner of Mental Health

3485 and Addiction Services and two members selected by the Behavioral
3486 Health Partnership Oversight Council, established pursuant to section
3487 95 of this act. Members of the committee shall have requisite expertise
3488 or experience in behavioral health services.

3489 Sec. 97. (NEW) (*Effective July 1, 2005*) The Departments of Children
3490 and Families and Social Services shall develop consumer grievance
3491 procedures and shall submit such procedures to the Behavioral Health
3492 Partnership Oversight Council for review and comment. The
3493 Departments of Children and Families and Social Services shall
3494 establish time frames for appealing decisions made by the
3495 administrative services organization, including an expedited review in
3496 emergency situations. Any procedure for appeals shall require that an
3497 appeal be heard not later than thirty days after such appeal is filed and
3498 shall be decided not later than forty-five days after such appeal is filed.

3499 Sec. 98. (NEW) (*Effective July 1, 2005*) On or before October 1, 2006,
3500 and annually thereafter, the Commissioners of Children and Families
3501 and Social Services shall conduct an evaluation of the Behavioral
3502 Health Partnership and shall report, in accordance with section 11-4a
3503 of the general statutes, to the joint standing committees of the General
3504 Assembly having cognizance of matters relating to appropriations and
3505 the budgets of state agencies, public health and human services on the
3506 provision of behavioral health services under the Behavioral Health
3507 Partnership, including information on the status of the administrative
3508 services organization implementation, the status of the collaboration
3509 among the Departments of Children and Families and Social Services,
3510 the services provided, the number of persons served, program
3511 outcomes and spending by child and adult populations.

3512 Sec. 99. (NEW) (*Effective July 1, 2005*) The Department of Children
3513 and Families shall monitor the implementation of the Behavioral
3514 Health Partnership and shall report annually to the joint standing
3515 committees of the General Assembly have cognizance of matters
3516 relating to human services, public health and appropriations and the
3517 budgets of state agencies as to any estimated cost savings, if any,

3518 resulting from implementation of the Behavioral Health Partnership.

3519 Sec. 100. (NEW) (*Effective July 1, 2005*) (a) The Departments of
3520 Children and Families and Social Services may establish provider
3521 specific inpatient, partial hospitalization, intensive outpatient and
3522 other intensive service rates. Within available appropriations, the
3523 initial rates shall not be less than each provider's blend of rates from
3524 the HUSKY Plans in effect on July 1, 2005, unless the date of
3525 implementation of the Behavioral Health Partnership is later than
3526 January 1, 2006. If such implementation date is later than January 1,
3527 2006, such initial rates, within available appropriations, shall not be
3528 less than each provider's blend of rates in effect sixty days prior to the
3529 implementation date of the Behavioral Health Partnership. Within
3530 available appropriations, the departments may provide grant
3531 payments, where necessary, to address provider financial impacts. The
3532 departments may establish uniform outpatient rates allowing a
3533 differential for child and adult services. In no event shall such rate
3534 increases exceed rates paid through Medicare for such services. The
3535 Behavioral Health Partnership Oversight Council shall review any
3536 such rate methodology as provided for in subsection (b) of this section.
3537 Notwithstanding the provisions of sections 17b-239 and 17b-241 of the
3538 general statutes, rates for behavioral health services shall be
3539 established in accordance with this section.

3540 (b) All proposals for initial rates, reductions to existing rates and
3541 changes in rate methodology within the Behavioral Health Partnership
3542 shall be submitted to the Behavioral Health Partnership Oversight
3543 Council for review. If the council does not recommend acceptance, it
3544 may forward its recommendation to the joint standing committees of
3545 the General Assembly having cognizance of matters relating to public
3546 health, human services and appropriations and budgets of state
3547 agencies. The committees shall hold a joint public hearing on the
3548 subject of the proposed rates, to receive the partnership's rationale for
3549 making such a rate change. Not later than ninety days after submission
3550 by the departments, the committees of cognizance shall make
3551 recommendations to the departments regarding the proposed rates.

3552 The departments shall make every effort to incorporate
3553 recommendations of both the council and the committees of
3554 cognizance when setting rates.

3555 Sec. 101. (NEW) (*Effective from passage*) (a) The Departments of
3556 Children and Families and Social Services shall enter a joint contract
3557 with an administrative services organization to perform eligibility
3558 verification, utilization management, intensive care management,
3559 quality management, coordination of medical and behavioral health
3560 services, provider network development and management, recipient
3561 and provider services and reporting. The contract shall provide for the
3562 organization to commence such activities on or after October 1, 2005.

3563 (b) Claims under the Behavioral Health Partnership shall be paid by
3564 the Department of Social Services' Medicaid management information
3565 systems vendor, except that the Department of Children and Families
3566 may, at its discretion, continue to use existing claims payment systems.

3567 (c) The administrative services organization shall authorize services,
3568 based solely on guidelines established by the clinical management
3569 committee, established pursuant to section 96 of this act. The
3570 administrative services organization may make exceptions to the
3571 guidelines when requested by a member, or the member's legal
3572 guardian or service provider, and determined by the administrative
3573 services organization to be in the best interest of the member.
3574 Decisions regarding the interpretation of such guidelines shall be
3575 made by the Departments of Children and Families and Social
3576 Services. No administrative services organization shall have any
3577 financial incentive to approve, deny or reduce services. The
3578 administrative services organization shall ensure that service providers
3579 and persons seeking services have timely access to program
3580 information and timely responses to inquiries, including inquiries
3581 concerning the clinical guidelines for services.

3582 (d) The administrative services organization shall provide or
3583 arrange for on-site assistance to facilitate the appropriate placement, as

3584 soon as practicable, of children with behavioral health diagnoses who
3585 the administrative services organization knows to have been in an
3586 emergency department for over forty-eight hours. The administrative
3587 services organization shall provide or arrange for on-site assistance to
3588 arrange for the discharge or appropriate placement, as soon as
3589 practicable, for children the administrative services organization
3590 knows to have remained in an inpatient hospital unit for more than
3591 five days longer than is medically necessary, as agreed by the
3592 administrative services organization and the hospital.

3593 (e) The Departments of Children and Families and Social Services
3594 shall develop, in consultation with the Behavioral Health Partnership,
3595 a comprehensive plan for monitoring the performance of the
3596 administrative services organization which shall include data on
3597 service authorizations, individual outcomes, appeals, outreach and
3598 accessibility, comments from program participants compiled from
3599 written surveys and face-to-face interviews.

3600 (f) The Behavioral Health Partnership shall establish policies to
3601 coordinate benefits received under the partnership with those received
3602 through Medicaid managed care organizations for persons covered by
3603 both a Medicaid managed care organization and the Behavioral Health
3604 Partnership. Such policies shall specify a coordinated delivery of both
3605 physical and behavioral health care. The policies shall be submitted to
3606 the Behavioral Health Partnership Oversight Council for review and
3607 comment.

3608 Sec. 102. (NEW) (*Effective July 1, 2005*) The Commissioner of
3609 Children and Families shall have the authority to certify providers of
3610 behavioral health Medicaid early periodic screening, detection and
3611 treatment and rehabilitation services for HUSKY Plan Part A for the
3612 purpose of coverage of Medicaid early periodic screening, detection
3613 and treatment or optional rehabilitation services. The Commissioner of
3614 Children and Families may adopt regulations, in accordance with the
3615 provisions of chapter 54 of the general statutes, for purposes of
3616 certification of such providers. The commissioner may implement

3617 policies and procedures for purposes of such certification while in the
 3618 process of adopting such policies or procedures in regulation form,
 3619 provided notice of intention to adopt the regulations is printed in the
 3620 Connecticut Law Journal not later than twenty days after
 3621 implementation and any such policies and procedures shall be valid
 3622 until the time the regulations are effective.

3623 Sec. 103. (*Effective July 1, 2005*) The sum of \$150,000 shall be
 3624 transferred from the appropriation to the Department of Social
 3625 Services, for Medicaid, for the fiscal year ending June 30, 2006, and the
 3626 fiscal year ending June 30, 2007, to the Department of Mental Health
 3627 and Addiction Services, for the Governor's Partnership to Protect
 3628 Connecticut's Workforce.

3629 Sec. 104. Sections 17a-22e, 17b-274b and 17b-362 of the general
 3630 statutes are repealed. (*Effective July 1, 2005*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2005</i>	17b-261
Sec. 2	<i>July 1, 2005</i>	17b-104(b)
Sec. 3	<i>July 1, 2005</i>	17b-7a
Sec. 4	<i>July 1, 2005</i>	17b-280(a)
Sec. 5	<i>July 1, 2005</i>	17b-292(h)
Sec. 6	<i>July 1, 2005</i>	17b-239(g)
Sec. 7	<i>July 1, 2005</i>	17b-295
Sec. 8	<i>July 1, 2005</i>	17b-277
Sec. 9	<i>July 1, 2005</i>	17b-292
Sec. 10	<i>July 1, 2005</i>	17b-342(i)
Sec. 11	<i>July 1, 2005</i>	New section
Sec. 12	<i>July 1, 2005</i>	16a-46(a)
Sec. 13	<i>July 1, 2005</i>	17b-192(c)
Sec. 14	<i>July 1, 2005</i>	17b-490(b)
Sec. 15	<i>July 1, 2005</i>	17b-279
Sec. 16	<i>July 1, 2005</i>	17b-274(c)
Sec. 17	<i>from passage</i>	17b-491a
Sec. 18	<i>July 1, 2005</i>	17b-274d
Sec. 19	<i>July 1, 2005</i>	New section

Sec. 20	<i>July 1, 2005</i>	17b-490
Sec. 21	<i>July 1, 2005</i>	17b-491(a)
Sec. 22	<i>July 1, 2005</i>	17b-492
Sec. 23	<i>July 1, 2005</i>	17b-264
Sec. 24	<i>July 1, 2005</i>	17b-266(a)
Sec. 25	<i>July 1, 2005</i>	17b-267(a)
Sec. 26	<i>July 1, 2005</i>	17b-272
Sec. 27	<i>July 1, 2005</i>	53a-290
Sec. 28	<i>July 1, 2005</i>	New section
Sec. 29	<i>July 1, 2005</i>	New section
Sec. 30	<i>July 1, 2005</i>	New section
Sec. 31	<i>July 1, 2005</i>	17a-218
Sec. 32	<i>July 1, 2005</i>	17a-485c
Sec. 33	<i>July 1, 2005</i>	New section
Sec. 34	<i>July 1, 2005</i>	17b-812
Sec. 35	<i>from passage</i>	New section
Sec. 36	<i>July 1, 2005</i>	New section
Sec. 37	<i>from passage</i>	New section
Sec. 38	<i>July 1, 2005</i>	17b-106(a)
Sec. 39	<i>July 1, 2005</i>	17b-802(a)
Sec. 40	<i>from passage</i>	17b-261a
Sec. 41	<i>July 1, 2005</i>	17b-354(a)
Sec. 42	<i>from passage</i>	New section
Sec. 43	<i>from passage</i>	17a-93
Sec. 44	<i>October 1, 2005</i>	17b-93(c)
Sec. 45	<i>October 1, 2005</i>	New section
Sec. 46	<i>July 1, 2005</i>	New section
Sec. 47	<i>July 1, 2005</i>	HB 6940 (current session), Sec. 78
Sec. 48	<i>July 1, 2005</i>	HB 6940 (current session), Sec. 79
Sec. 49	<i>July 1, 2005</i>	17b-340(f)(4)
Sec. 50	<i>July 1, 2005</i>	HB 6940 (current session), Sec. 82
Sec. 51	<i>July 1, 2005</i>	17b-340(h)(1)
Sec. 52	<i>July 1, 2005</i>	HB 6940 (current session), Sec. 85
Sec. 53	<i>January 1, 2007</i>	New section
Sec. 54	<i>July 1, 2005</i>	New section
Sec. 55	<i>from passage</i>	New section
Sec. 56	<i>July 1, 2005</i>	8-3e

Sec. 57	July 1, 2005	New section
Sec. 58	July 1, 2005	19a-638(a)
Sec. 59	July 1, 2005	New section
Sec. 60	July 1, 2005	19a-490
Sec. 61	July 1, 2005	19a-630
Sec. 62	July 1, 2005	New section
Sec. 63	July 1, 2005	New section
Sec. 64	July 1, 2005	New section
Sec. 65	July 1, 2005	New section
Sec. 66	July 1, 2005	New section
Sec. 67	July 1, 2005	New section
Sec. 68	<i>from passage</i>	New section
Sec. 69	October 1, 2005	New section
Sec. 70	October 1, 2005	New section
Sec. 71	October 1, 2005	New section
Sec. 72	October 1, 2005	19a-14(c)
Sec. 73	<i>on and after the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner</i>	19a-14(c)
Sec. 74	October 1, 2005	19a-88(e)
Sec. 75	<i>on and after the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner</i>	19a-88(e)
Sec. 76	October 1, 2005	20-9

Sec. 77	<i>On and after the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner</i>	20-9
Sec. 78	<i>July 1, 2005</i>	17a-450(b)
Sec. 79	<i>July 1, 2005</i>	17a-458(c)
Sec. 80	<i>July 1, 2005</i>	New section
Sec. 81	<i>July 1, 2005</i>	New section
Sec. 82	<i>July 1, 2005</i>	19a-405
Sec. 83	<i>July 1, 2005</i>	New section
Sec. 84	<i>from passage</i>	New section
Sec. 85	<i>from passage</i>	New section
Sec. 86	<i>from passage</i>	New section
Sec. 87	<i>July 1, 2005</i>	New section
Sec. 88	<i>July 1, 2005</i>	New section
Sec. 89	<i>from passage</i>	38a-1041
Sec. 90	<i>from passage</i>	New section
Sec. 91	<i>from passage</i>	New section
Sec. 92	<i>July 1, 2005</i>	New section
Sec. 93	<i>July 1, 2005</i>	New section
Sec. 94	<i>from passage</i>	17a-22f
Sec. 95	<i>from passage</i>	New section
Sec. 96	<i>July 1, 2005</i>	New section
Sec. 97	<i>July 1, 2005</i>	New section
Sec. 98	<i>July 1, 2005</i>	New section
Sec. 99	<i>July 1, 2005</i>	New section
Sec. 100	<i>July 1, 2005</i>	New section
Sec. 101	<i>from passage</i>	New section
Sec. 102	<i>July 1, 2005</i>	New section
Sec. 103	<i>July 1, 2005</i>	New section
Sec. 104	<i>July 1, 2005</i>	Repealer section